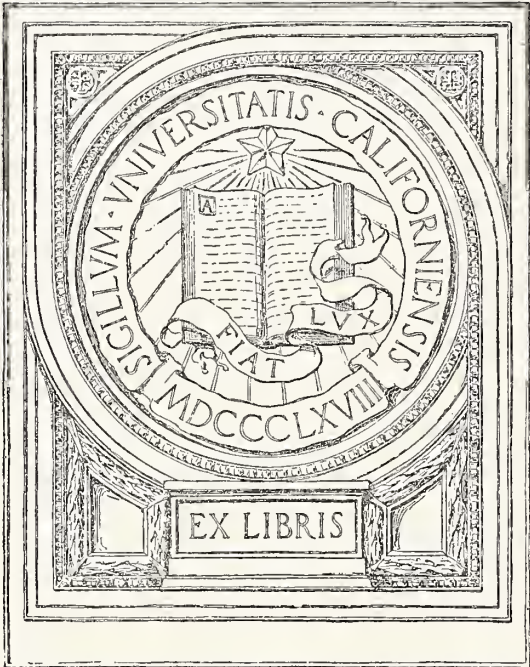


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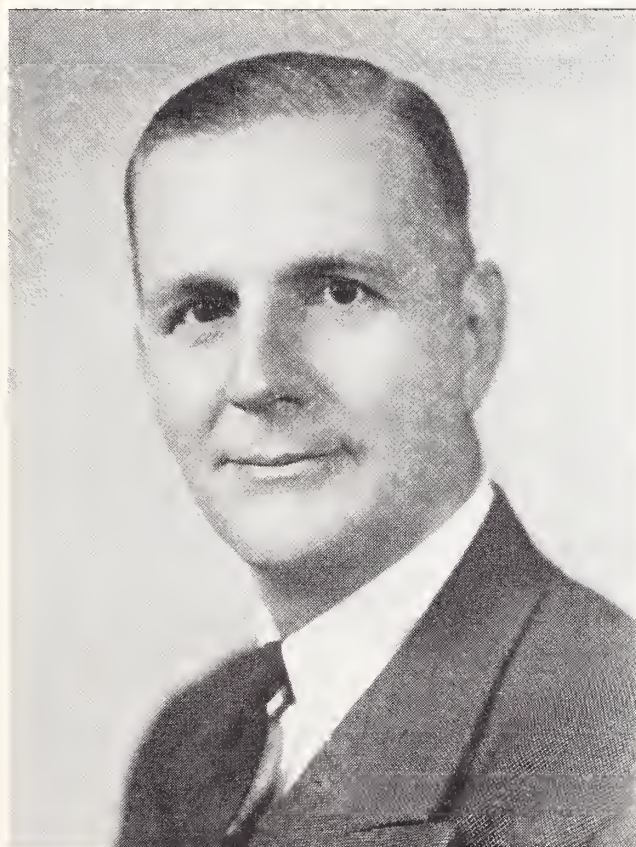
January, 1954

NUMBER 1

PRESIDENTIAL EDITORIAL¹

THE GENERAL PRACTITIONER—SPECIALIST TEAM

BENDER B. KNEISLEY, M.D.²



BENDER B. KNEISLEY, M.D.

It is agreed, without exception, by medical men, that the true reason for the practice of their profession is to serve the best interests of the patient. Fundamentally, all other interests, although of some importance, should be secondary.

¹ Editor's note: Dr. Kneisley is a General Practitioner.

² President, Medical and Chirurgical Faculty, 1954.

In Hagerstown, Maryland, with a population of forty thousand people, the general practitioner (forty percent) and men in the specialty fields (sixty percent) have long enjoyed a very helpful and pleasant relationship. There is a feeling of mutual respect. Clinical pathological conferences are attended by both general and specialty men, and both actively participate in the meetings. Consultations occur regularly and their number is probably what might be considered average for such a community. In short, the general practitioner-specialist team works well in a small city of forty thousand people.

With the rapid advancement and change in medical problems, both as to diagnosis as well as treatment, the patient will need help from many medical sources in order that the wide spectrum of medical knowledge may be brought to bear on his disease. It is therefore logical and sound that the general practitioner and specialist in many instances operate as a team if the patient is to get the full benefit of present day medicine. The word *team* is emphasized because of its very meaning. Of course, much can be, and is being accomplished by each doctor going his own way, a sort of every man for himself attitude. But if this attitude becomes too general or too frequently practiced, the patient's interest may suffer or even be in jeopardy. Obviously, a general practitioner, able as he may be, should not continue to assume the responsibility of a seriously ill patient whose affliction is undiagnosed. And even if the diagnosis is made, and be correct, consultation is in order in many cases. One feels that most family doctors will and do ask for consultations. Surely it is for the best interest of the patient, and at the same time the family physician gathers valuable information.

The general practitioner-specialist team at work can be a most pleasant experience as well as rewarding to all participants. Such a team will not have the star player philosophy but will cooperate to give the best efforts to win the game—for the patient.

Osler, in his presidential address to the Medical and Chirurgical Faculty on April 27th, 1897, among other good thoughts, had this to say:—

“No class of men needs friction so much as physicians; no class gets less. The daily round of a busy practitioner tends to develop an egoism of a most intense kind, to which there is no antidote. The few set backs are forgotten, the mistakes are often buried, and ten years of successful work tend to make a man touchy, dogmatic, intolerant of correction and abominably self-centered. To this mental attitude the Medical Society is the best corrective, and a man misses a good part of his education who does not get knocked about a bit by his colleagues in discussions and criticisms.” . . .³

If medicine is to have its best chance for the patient, doctors will have to keep abreast in a period of fast paces, and in many instances, they will have to operate mutually, with consideration and understanding of the problems of each.

³ Cushing, Harvey, *The Life of Sir William Osler*, Vol. I, Page 447, 1925.

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PLEASE ANSWER THE QUESTIONNAIRE

From the Council on Medical Education and Hospitals of the A.M.A.

—THIS IS OUR OBLIGATION—

Keeping up-to-date in medicine is essential for the physician who is endeavoring to render good medical care to his patients. In order to aid those who are charged with the responsibility of helping you in this phase of your professional life, the Council on Medical Education and Hospitals is presently making an intensive nationwide study of the problems in this field. The medical schools, medical societies, and other organizations engaged in postgraduate and other programs have been canvassed for their ideas.

To balance this picture, the views of the practicing physician must be obtained. The ultimate benefit of this study should be an extension and improvement of the ways and means that you and your colleagues have found most effective in keeping up-to-date.

It is urged that a questionnaire being sent to you by the A.M.A. Council on Medical Education and Hospitals be completed and promptly returned. It is to your interest to do so!

MRS. HOBBY URGES MORE STATE MONEY BE USED IN REHABILITATION

The AMA Washington Letter, No. 44

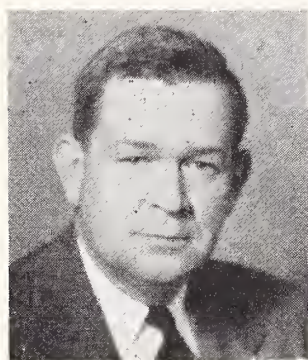
The time has come to reverse the trend and use more state and less federal money in vocational rehabilitation work, in the opinion of Secretary Hobby. Addressing the National Rehabilitation Conference, the Secretary of Health, Education, and Welfare noted that in 1921 when the program started the federal share was only one-third. (However, this was for only a part of a year.) Federal contributions reached a peak of 73.5% in 1947, and have declined to about two-thirds for the current fiscal year. Mrs. Hobby remarked that appropriations committees in Congress already have begun to "question the wisdom of providing such a proportion of federal funds for a program keyed to the principle of state operations. . . . To me it is simply additional evidence that the time has come to review and inventory our programs."

Without further elaboration, Mrs. Hobby said that her department "plans to propose legislation to strengthen administration of the program and to permit new approaches to old problems, without disrupting the important work which the state agencies are carrying on daily."

The Secretary indicated she thought the Manion Commission would look into such programs as vocational rehabilitation. She said the commission, currently studying U. S.-state relations, "offers a promise for a healthy re-examination of federal, state and local governmental interrelations, and I think we must all welcome their efforts to clarify the roles of each."

Maryland Academy of General Practice

Executive Secretary—Mr. William J. Wiscott, 1818 Ashburton Street, Baltimore



MERRILL M. CROSS, M.D.,
President-elect



LAURISTON L. KEOWN, M.D.,
President

NEW OFFICERS

At the Annual Meeting in the Lord Baltimore Hotel, October 20, 1953, the following officers were elected for 1954:

President: LAURISTON L. KEOWN, M.D., Baltimore

President-Elect: MERRILL M. CROSS, M.D., Silver Spring

Vice Presidents: NATHAN E. NEEDLE, M.D., Baltimore, N. E. SARTORIUS, JR., M.D., Pocomoke City, ROBERT VAN L. CAMPBELL, M.D., Hagerstown

Secretary & Treasurer: WILLIAM T. LAYMAN, M.D., Hagerstown

Executive Secretary: MR. WILLIAM J. WISCOTT, Baltimore

New Directors: ROBERT E. FARBER, JR., M.D., Sparrows Point, ROBERT W. FARR, M.D., Chestertown, GERALD W. LEVAN, M.D., Boonsboro.

Delegate to A.A.G.P.: C. F. O'DONNELL, M.D., Towson

Alternate Delegate to A.A.G.P.: WILLIAM D. CAMPBELL, M.D., Hagerstown

Holdover Directors: WILLARD S. PARSON, M.D., Baltimore, H. A. ROBBINS, M.D., Berlin, HUGH W. WARD, M.D., Owings.

Holdover Delegates: JAMES FRENKIL, M.D., Baltimore, WILLARD S. PARSON, M.D., Baltimore.

"GENERAL PRACTITIONER OF THE YEAR"

Dr. Bender B. Kneisley of Hagerstown was named "General Practitioner of the Year" by his fellow members of the Maryland Academy at the Lord Baltimore Hotel, October 21, 1953.

Nomination of Dr. Kneisley as the State's outstanding family doctor came at the banquet which culminated the all-day scientific session of the Academy, attended by some 300 doctors.

Dr. Louis Krause, who presented a bronze plaque award, cited Dr. Kneisley for his exemplary work as both physician and citizen and his untiring efforts in behalf of improved medical services to the State.

Dr. Kneisley was one of the original organizers of the Maryland Academy, and has served on important committees and was elected Vice President.

LADIES AUXILIARY

At the invitation of Dr. Katherine Kemp some forty wives of members of the Academy, met at luncheon in the Hutzler's Tea Room, at noon, October 21, 1953, to consider the idea of organizing a "Ladies Auxiliary" to the Maryland Academy. The matter was discussed, approved, and the following officers were elected for 1954:

President: MRS. CHARLES F. O'DONNELL, 7501 York Rd., Towson

Vice Presidents: MRS. HAROLD B. PLUMMER, P.O. Box 95, Preston, MRS. MERRILL M. CROSS, Silver Spring, MRS. NATHAN E. NEEDLE, 6006 Park Heights Ave., Baltimore

Recording Secretary: MRS. KENNETH KRULEVITZ, 5100 Laurel Ave., Baltimore

Corresponding Secretary: MRS. LESTER N. KOLMAN, 3700 Labyrinth Rd., Baltimore

Treasurer: MRS. BOWIE LINN GRANT, Shady Side

NEW MEMBERS

The following physicians have been elected to membership in the Maryland Academy:

Active Membership:

Samuel Allen, 18 Fawcett St., Kensington, Md.
 Paul Lubin, 320 Patapsco Ave., Baltimore 25, Md.
 Benjamin Miller, 2030 Wilkens Ave., Baltimore 23, Md.
 Milton Siscovick, 1429 W. Fayette St., Baltimore 23, Md.
 Imre Neubauer, 936 Patapsco Ave., Baltimore 25, Md.
 Aaron Charles Sollod, 707 E. Fort Ave., Baltimore 30, Md.
 Andrew C. Mitchell, 228 N. Division, Salisbury, Md.
 George B. Patrick, 8700 Colesville Rd., Silver Spring, Md.

John A. Scharffenberg, 804 Houston Ave., Takoma Park, Md.
 Theodor Sattelmanier, Stevensville, Md.

Associate Membership:

Arthur Rudolph Bergman, 8801 Colesville Rd., Silver Spring, Md.
 William Horace Franklin Warthen, Baltimore County Health Dept., County Office Bldg., Towson 4, Md.
 Robert Wilson Ard, 318 N. Potomac St., Hagerstown, Md.
 Willard F. Smith, Rock Hall, Md.
 Donald F. Bartley, 9 N. Hanson St., Easton, Md.

Emeritus Membership:

Norman E. Sartorius, Sr., Pocomoke City, Md.

VA TO ASK FINANCIAL INFORMATION IN NON-SERVICE CONNECTED CASES

The AMA Washington Letter, No. 45

Under a new policy, Veterans Administration from now on will ask additional information from a veteran applying for hospitalization of a non-service connected condition. Previously, the veteran had only to answer the question: "Are you financially able to pay the necessary expense of hospitalization or domiciliary care?" If the answer was "no," the veteran was eligible. Now the veteran will be required to answer the following additional questions:

1. What is the current value of your property, real and personal? 2. What is the current amount of your ready assets in the form of cash, bank deposits, savings bonds, etc? 3. If you own real property, what is the approximate amount of the unpaid mortgage or other indebtedness? 4. What are your average monthly expenditures, including mortgage payments and all other personal expenses, including your expenses for dependents? 5. What was your average monthly income for the last six months, from all sources?

However, VA states that, "This addendum may be used in no way whatever to deny hospitalization to a veteran, as the law specifically provides that 'the statement under oath of the applicant. . . shall be accepted as sufficient evidence of inability to defray necessary expenses.' (It) is designed to protect applicants for hospitalization, and veterans generally, from charges of 'chiseling' on the government."

Scientific Papers

LATE COMPLICATIONS OF DIABETES: PREVENTION AND TREATMENT*

ALEXANDER MARBLE, M.D.†

For some years following the introduction of insulin in 1922 the experience with patients was so favorable and so encouraging that hopes were raised that the problem of diabetes had been solved. It soon became apparent that with insulin, acidosis and coma could be prevented and that, if they did occur, treatment was highly satisfactory if vigorous and if started early enough. Insulin enabled the diabetic to be brought safely through infections and surgical procedures which otherwise were hazardous. It was found that not only could glycosuria and hyperglycemia be controlled but also that hyperlipemia and hypercholesterolemia could usually be prevented. Above all, the length of life after onset of diabetes could be greatly prolonged. This was most striking among diabetic children and adolescents with whom diabetes in the past had been uniformly fatal after a short course of usually not more than 2 or 3 years and often less.

During these early insulin days the handwriting was undoubtedly being inscribed upon the wall but we were unable to read it clearly until some 15 or 20 years after insulin was first used, i.e., in the period 1937–1942. At that time those clinicians who had the opportunity of observing large groups of juvenile diabetics began to realize that after some 10, 15 or more years of

diabetes, these young patients often exhibited certain complications, chiefly of a vascular nature, which had a definite tendency to progression. One noted also that not infrequently there was evidence of deleterious effect upon the nervous system; neuropathies included not only peripheral neuritis but also paresis of the urinary bladder, “diabetic diarrhea,” “neuropathic foot” and postural hypotension.

As the result of this experience in the insulin era the concept has arisen that the metabolic disturbance of diabetes, if held in check incompletely, gradually brings about harmful effects throughout the body. Such effects are seen most prominently in the vascular and nervous systems. The degenerative processes are operative at all ages but impress the observer most vividly when seen in the young. If diabetes has its onset at the age of 55 years, death from some vascular complication at age of 75 after 20 years of diabetes is not nearly so impressive as a fatal issue in a person of 35 years whose onset of diabetes was at age 15. For purposes of study these young patients are much more suitable because in them one can observe the effects of diabetes in pure form apart from the many influences which affect older persons and confuse the situation.

That the late complications of long-term diabetes constitute a major problem is now an established fact supported by the daily experience of patients and physicians everywhere. In the present paper an attempt will be made to answer the following questions: (1) How common are such complications, particularly of the

* Read at the fifth annual Scientific Assembly, Maryland Academy of General Practice, Baltimore, October 21, 1953.

† From the Joslin Clinic and the Baker Clinic Research Laboratory, New England Deaconess Hospital, Boston, Mass.

Clinical Associate in Medicine, Harvard Medical School, and Physician, New England Deaconess Hospital, Boston, Mass.

vascular system? (2) What is their cause? How may they be prevented? (3) How can they be treated, if once present?

INCIDENCE

Retinitis. Retinopathy is one of the earliest evidences of vascular involvement and the one which from the patient's standpoint is often the most distressing. Characteristic are small, deep retinal hemorrhages or microaneurysms and waxy exudates. These tend to increase and as hypertension and renal disease develop, are joined by flame-shaped hemorrhages and fluffy exudates of the "cotton-wool" type. Hemorrhages into the vitreous may occur. Finally, fibrous tissue accompanied by new vessels may develop and extend until the full-blown condition of retinitis proliferans may occur. Blindness or near-blindness may develop.

In our own series of 451 patients, carefully studied,¹ with onset of diabetes under the age of 30 years and with duration of the disease from 10 to 36 years, the incidence of retinopathy was as shown in Table 1. It is evident that after 15 years of diabetes about $\frac{3}{4}$ of the patients had retinitis to some extent and well over half had the more severe grades. Such a high incidence is disheartening but one feels encouraged that over 40 per cent of the group showed little or no retinitis after 20 or more years of diabetes. The outlook is bad but not nearly as bad as has sometimes been stated.

Arterial calcification. Although arteriosclerosis, including atherosclerosis, is the most important foe of the older diabetic, it affects patients of all ages with long-term diabetes. In the older diabetic, presumably because of the additive effect of arteriosclerosis arising from influences apart from diabetes, this form of vascular disease is the greatest single cause of death. Thus, among 656 diabetic patients dying between 1950 and 1952, heart disease, chiefly arteriosclerotic in nature, accounted for 47.6 per cent of deaths.

TABLE 1

Incidence of Retinopathy in 451 Diabetic Patients with Long-Term Diabetes

DURATION OF DIABETES	NUMBER OF PATIENTS	RETINOPATHY*	
		Grades 2, 3, 4	All Grades
years		per cent	per cent
10-14.9.....	154	35	59
15-19.9.....	108	56	78
20 and over.....	189	57	73

* Retinopathy was graded as follows: Grade 1—few tiny hemorrhages and/or microaneurysms in one or both retinas with no exudates; Grade 2—several hemorrhages and/or microaneurysms in both fundi and a few to many hard and/or soft white exudates bilaterally; Grade 3—many hemorrhages and/or aneurysms bilaterally, some splinter hemorrhages in deep and superficial layers of the retina, and many exudates in both fundi; Grade 4—retinitis proliferans, retinal detachment and acute or chronic hemorrhagic glaucoma.

In the same series of 451 young patients just mentioned in whom diabetes had been present for 10 to 36 years, a study of the incidence of arterial calcification was made. It was realized that the flecks and lines seen in x-rays of the aorta, pelvic arteries and vessels of the legs represent calcium deposits in the media of arteries and may not give an accurate impression of the incidence of arteriosclerosis in general. However, this method of study was chosen because of the ease with which it could be carried out and the difficulty of devising any better way. The results are shown in Table 2.

Nephropathy. Experience has shown that the renal disease of the person with long-term diabetes is a mixed nephropathy² to which arteriosclerosis, arteriolarsclerosis, acute and chronic pyelonephritis and intercapillary glomerulosclerosis all contribute. Although the basic lesions are only in part vascular in nature, diabetic nephropathy may rightly be included among the vascular complications of diabetes. It occurs not only in older diabetic patients but frequently and most characteristically in relatively young persons in their thirties and forties who have had diabetes for 15, 20 or more years. Clinically diabetic nephropathy is manifested

TABLE 2
Incidence of Arteriosclerosis in 451 Patients with Long-Term Diabetes

DURATION OF DIABETES years	NUMBER OF PATIENTS	ARTERIAL CALCIFICATION*			
		Minimal	Mod.	Marked	Total
10-14.9.....	154	28	12	10	50
15-19.9.....	108	18	20	26	64
20 and over.....	189	16	19	49	84

* Arterial calcification was graded as follows: Minimal—one or more specks of density in linear arrangement in one or two small areas not over 1 or 2 cm. in length, with no calcification visible in the remainder of the arteries of the lower legs and pelvis and aorta; Moderate—tiny areas of density arranged in linear form in parallel order for lengths of more than 1 or 2 cm. in one or more arteries; Marked—more extreme degrees of density in the arteries and their branches in the legs and pelvis or in the aorta.

by albuminuria, hypertension, retinopathy, peripheral edema and azotemia, progressing to death, usually in uremia. Among our study group of 451 patients, there were 101 or 22 per cent who showed definite evidence of diabetic nephropathy. In recent years renal disease with ultimate failure has loomed increasingly high as a cause of death among patients with onset of diabetes in childhood and adolescence. Among 119 such patients dying between January 1, 1950 and August 31, 1953, nephritis accounted for 75 or 63 per cent of the deaths (see Table 3).

TABLE 3
Causes of Death in 600 Patients with Onset of Diabetes under the Age of 15 years

Period	1898 1922	1922 1936	1937 1943	1944 1949	1950 1953
No. of Patients Dying	157	99	81	144	119
CAUSE OF DEATH	per cent	per cent	per cent	per cent	per cent
Coma.....	86.0	56.6	27.2	9.7	6.7
Coronary.....	—	—	2.5	10.4	5.9
Nephritis.....	—	2.0	12.3	36.8	63.0
Cer. Vasc.....	—	—	1.2	2.1	5.9
Infections*.....	6.4	23.2	24.7	6.9	8.4
Tuberculosis.....	—	8.1	9.9	11.1	1.7

* Excluding tuberculosis.

Compiled by Statistical Department, Metropolitan Life Insurance Company.

ETIOLOGY AND PREVENTION

It is far easier to arrive at figures for the incidence of vascular disease among diabetic patients than it is to demonstrate the cause. In fact, the etiology of such complications is at present the most disputed point in the field of diabetes. On the one hand there are those who believe that the development of degenerative complications is simply a matter of time and not dependent upon the degree of control of diabetes. Proponents of this idea often have suggested that some unrecognized "X" factor, running concurrently with the diabetes, may be responsible. They maintain that all that is necessary in treatment is sufficient dietary restriction and insulin treatment to keep the patient free from ketosis and overt diabetic symptoms. In general, such clinicians pay little or no attention to hyperglycemia or glycosuria. On the other hand are those who regard the vascular complications of long-term diabetes as directly related to the degree of control of diabetes over the years. These clinicians believe in controlling hyperglycemia and glycosuria as closely as possible short of producing frequent or severe insulin reactions. They believe that vascular disease is due directly to the poorly understood metabolic disturbance of diabetes of which a high blood sugar, urine sugar and ketosis are easily measured surface manifestations. Duration of diabetes is of importance chiefly in allowing more time for the harmful influences arising from the incompletely controlled diabetic condition to have their effect.

The writer aligns himself with the latter group and believes firmly that with the means of treatment now available, careful control of diabetes over the years is the only way to prevent or postpone the long-term complications of diabetes. This belief is based not only on clinical impressions but also on the results of a careful study of the 451 youthful patients to which reference has already been made. In this survey, the degree of control of diabetes maintained by patients over 10 to 36 years was graded. In

addition, the presence and/or degree of retinopathy, arterial calcification and nephropathy were carefully noted. Then the two types of data were matched in an attempt to discover correlations, if any. Among 32 patients who had maintained excellent or good control for 20 or more years, none had grade 4 retinopathy and one had grade 3 changes. No patient with excellent control had more than minimal (grade 0 or 1) retinopathy. On the other hand, among 157 patients with diabetes of the same duration who had maintained only fair or poor control, 26 (16%) had grade 4 retinopathy, and an additional 24 (15%) had grade 3. Among 189 patients with diabetes of 20 or more years' duration, 60% of the 32 with excellent or good control had either no arterial calcification or only minimal changes, whereas only 20% of 157 patients with fair or poor control had only these lesser degrees of arteriosclerosis. None of the 11 patients with excellent control and only one of the 50 with good control showed diabetic nephropathy; however, 17% of 92 patients with fair control and 28 per cent of 298 patients with poor control gave evidence of this condition. It seemed evident to us from this study that at all stages of duration of diabetes, the incidence of retinopathy, arterial calcification and nephropathy was significantly less in patients who had maintained excellent or good control of diabetes over the years. The obvious conclusion was that by careful and continuous control the long-term complications of diabetes may be prevented or postponed.

TREATMENT OF COMPLICATIONS

Until such time as the prevention of the late vascular and nervous system complications of diabetes becomes more nearly possible, it is the responsibility of the physician to deal with the problem as best he can. As has already been brought out in some detail, we believe that if one were able to bring about "Ideal" control of diabetes, with entire freedom from ketosis, hyperglycemia and glycosuria over years of

time, such could be taken as an indication that harmful influences arising from underlying metabolic abnormalities had been counteracted. In such an ideal situation, one might reasonably expect absence of specific sequelae of diabetes. At present those degrees of control which we call "Excellent" or "Good" do not approach closely the level of "Ideal" control and hence complications continue to occur in spite of our best efforts. In dealing with them, the best treatment now available consists in bringing the diabetic condition under the best possible control and maintaining it at this level. This is accomplished by the furnishing of a truly adequate though restricted diet and by the giving of appropriate doses of that type of insulin best suited to the individual. Clinical experience shows that in this way we may justifiably hope to stay the progress of the degenerative lesions. However, one would like to use supporting measures and in the following discussion the experience of our group will be cited.

Retinopathy. First, as regards retinitis, we have found no specific remedy. For years we used rutin and related substances and, at times, with apparent benefit. However, as time has gone on we have become increasingly of the opinion that these drugs are not effective, at least when given orally. The same applies to ascorbic acid although certainly one should not withhold this vitamin from anyone with whom there is any suggestion of a specific deficiency. Vitamin B complex and its various component B vitamins have not yielded success. Lately, on the basis of the animal studies of Friedenwald,³ we have treated a series of patients with injections of sizable doses of Vitamin B₁₂ over weeks of time without definite benefit. Finally, with the dreaded retinitis proliferans, we have not seen consistent or lasting success with the use of cortisone, ACTH or x-ray treatment.

Arterial calcification. As with retinitis, it is far easier to devise a theoretically effective means for prevention of arteriosclerosis than it is to treat the complication once it occurs. All

signs point to the conclusion that if diabetes is kept under excellent control, if obesity is avoided and if the blood lipids and blood cholesterol can be kept at normal levels, degenerative changes in the walls of blood vessels may be postponed. Once arteriosclerosis is present, these measures may conceivably check progression. Evidence suggests that it is more important to avoid overnutrition and obesity than it is to restrict arbitrarily the amount of fat and cholesterol in the diet. Following the work of Gofman and associates⁴ in which it was shown that patients with myocardial infarctions had increased levels of lipoprotein molecules with S_f 10–30, the thought arose that, in addition to dietary treatment, such persons might be helped by injections of heparin. Some have reported improvement in angina pectoris by such treatment. In our own patients a carefully controlled study designed to test the efficacy of heparin in patients with peripheral vascular disease and intermittent claudication, gave no positive evidence of benefit.

The principles of treatment of the patient with angina pectoris, coronary sclerosis and myocardial infarction are the same in diabetics as in non-diabetics. However, experience forces one to the conclusion that the prognosis in the diabetic is in general not as good. Hence the diabetic must be watched even more carefully and therapeutic measures designed with even greater thought. Hypoglycemia due to insulin must be avoided but this does not by any means imply, as sometimes taught, that insulin should be discontinued in the diabetic who develops a myocardial infarction. In fact, the diabetic condition should be well controlled, always taking care to avoid overdosage with insulin.

Time and space do not permit an adequate discussion of the treatment of peripheral vascular disease. However, one should emphasize again the familiar but often disregarded fact that, despite impairment of circulation, a high percentage of the instances of gangrene with or without infection may be prevented by careful, daily care of the feet and the early treatment of

small lesions if they do appear. In this field the sulfonamides and the antibiotics have proved to be a real blessing; with the use of a carefully selected antibacterial agent many extremities may be saved and conservative rather than radical surgery be possible. The guiding principles of treatment in the patient with gangrene and infection are as follows: (1) early recognition and prompt institution of treatment; (2) complete bed rest; (3) use of the appropriate antibiotic in adequate dosage; (4) careful control of the diabetic condition with the supplying of a diet adequate in protein and vitamins; (5) such early surgery as is necessary to provide free drainage from areas of infection; and (6) definitive surgery at a carefully selected time with the thought of being as conservative as is consistent with healing of the operative wound. We have found the transmetatarsal amputation to be an extraordinarily useful procedure which in many patients has happily taken the place of a higher procedure at the lower leg or low thigh level. As secondary measures in treatment, we have been disappointed with the results of all drugs introduced thus far to improve circulation by vasodilatation. One procedure, lumbar sympathectomy, has seemed of value in those few patients in whom careful clinical observation has suggested that vasospasm may be playing a significant role. Sympathectomy in the average elderly diabetic with gangrene has proved useless.

Nephropathy. Once diabetic nephropathy has developed with its proteinuria, diminished renal function, azotemia, lowered serum protein and reversal of the A/G ration and with common accompaniments of hypertension, retinopathy and varying degrees of generalized arteriosclerosis, the capabilities of the physician are put to a severe test. The best that one can hope for is to stay the progress of the disease and often it does seem that with careful control of diabetes and meticulous attention to supporting measures, a good deal may be accomplished to prolong life and make it more comfortable and useful.

It is amazing at times to see patients who carry on at their jobs over months or even years with constant mild to moderate azotemia. Much help is gained from sensible restriction of activity, restriction of sodium in the diet, and the use of ammonium chloride and mercurial diuretics. Certainly, however, nephropathy is a condition to be prevented rather than treated.

Neuropathy. Earlier in the discussion mention was made of the influence of diabetes on the nervous system and the various types of neuropathy which may occur, particularly after some years of poor control. As a complication of long-term diabetes, neuropathy of some degree and of some form or other is relatively common. When seen as a full-blown peripheral neuritis it may be extremely unpleasant and even disabling for the patient and exasperating for the physician. Fortunately, if the diabetes is brought under control and kept in that state and if an adequate diet is supplied, the eventual prognosis is good. Pain finally disappears although it may take weeks, months or even years for relief to come. As accessory treatment we prescribe large amounts of vitamin B although rarely does one observe any specific or dramatic effect. Over the years we have used injections of crude liver extract, vitamin B complex, thiamine, British Anti-Lewisite, pregnant mammalian liver extract and finally vitamin B₁₂. With each of these agents we have in certain patients observed improvement which has seemed related to the treatment but it has been extremely difficult to be sure whether the results have been truly specific. One must be wary in drawing conclusions when the course of the disease is variable and ultimate relief from pain is to be expected anyway and when so many different agents seem at times to have been effective. Certainly the last word has not been said as regards the treatment of diabetic neuropathy.

SUMMARY

In the three decades since the introduction of insulin the mortality from diabetic coma has fallen steadily. With the additional aid of the

sulfonamides and the antibiotics, deaths from infections and from surgical complications have been greatly reduced. The greatest problem and the greatest challenge now lie in the late complications of diabetes affecting particularly the vascular and nervous systems. Although these are found in diabetics of all ages, they are most tragic when they occur in persons in their 30's or 40's who after 15, 20 or more years of diabetes are beset with retinitis seriously limiting vision, hypertension, vascular sclerosis and nephropathy. Many of these patients will have had symptomatic neuropathy during their diabetic lives. In this group of relatively young persons death takes place most commonly from renal involvement.

Treatment of these conditions, once established, leaves much to be desired. The greatest hope lies in prevention. Unbiased clinical studies among patients with onset of diabetes below the age of 25 years have shown that the most important influence is the degree of control of diabetes. Duration of diabetes is important but chiefly because it allows a greater number of years for deleterious influences to operate. It is those patients with the best control who after 20 years have the fewest and least marked degenerative changes. Conversely, it is among those patients whose diabetes has been least well controlled that one finds the most distressing sequelae of long-standing diabetes. Careful, continuous control must be the aim of the physician in the care of his diabetic patients.

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A NEW TREATMENT FOR BRONCHIAL ASTHMA*

CHARLES F. GESCHICKTER, M.D.†

The asthmatic has a twofold allergic response. The first to develop is the serologic response in which neutralizing antibodies against pollens, dusts, and other substances circulate in the serum. For several years this reaction usually produces no symptoms, and the patient is in a balanced allergic state, to use a phrase introduced by Vaughn.¹ The second response appears later after damage and inflammation of the bronchial tree has occurred as a result of repeated contact between the immune serum and the inhaled antigenic substances. This leads to a second group of immune bodies (sessile antibodies), which attach themselves both to the injured bronchial tissue and the offending substances, so there is localization and intensification of the allergic response in the respiratory tissues. This localizing response, which liberates among other substances both histamine and choline and which is associated with hypersecretion and muscle spasm in the bronchi, tends to be more persistent and self-perpetuating and converts the bronchi into a shock organ where the fixation response produces further local inflammation, creating more tissue damage and stimulating further the production and fixation of antibodies. The patient now develops cough, wheezing and dyspnea, characteristic of asthma.

The twofold problem of asthma therapy may be stated as follows: We must either increase the neutralizing bodies in the serum through repeated inoculation, so-called desensitization, or depress the inflammatory response in the shock organ. Neither procedure is curative regardless of the success of treatment along these lines as long as the asthmatic retains his inherited tendency to hyperimmune response.

* Supported by The Geschickter Fund for Medical Research, Inc.

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After an interval of two to six years without therapy he is capable of acquiring a second time both the serologic and shock organ responses which led to the original asthmatic attack. At times removal to a new environment or eliminating the offending substance will allow the susceptibility to remain dormant for want of a provocative agent. At other times the reticulo-endothelial system of the asthmatic will show involutional changes as his age advances, which will eliminate the asthmatic tendency.

The new method of asthma therapy reported here represents an attempt to provide a therapeutic agent which localizes in the respiratory tissue at the site of concentration of the fixation antibodies. For this purpose the nucleus of the quinine molecule, which is 6-methoxy-4-amino quinoline, was selected. During World War II such quinoline compounds synthesized as anti-malarial were shown to localize in both the respiratory tissue and in the reticuloendothelial structures. Expressed in terms of milligrams per kilogram of tissue (as measured in the monkey on daily doses of 25 mg. per kg. over a period of 30 days) showed the following tissue localization.

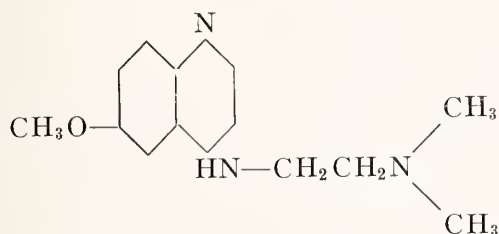
Plasma	0.6 mg./kg.
Brain	10 mg./kg.
Heart	20 mg./kg.
Kidney	30 mg./kg.
Spleen	40 mg./kg.
Lung	50 mg./kg.
Liver	70 mg./kg.

It will be seen that the maximum concentration of 4-amino quinoline is in the lungs and in the liver. This accounts for the pulmonary congestion observed in rats on high toxic chronic dosage and the finding of anorexia and sub-clinical jaundice observed in a patient on 5 mg. per kg. daily for a period of several weeks. The

anorexia and liver function returned to normal several days after withdrawal of the drug. Complete blood studies before and after therapy on the patients in this series showed no untoward effects on the formed elements of the blood.

Since the quinine nucleus has been previously shown by Wolf² to be anticholinergic and, therefore, a probable bronchial dilator, it would seem likely that by adding a suitable side-chain the quinoline nucleus could also be made antihistaminic. The final compound synthesized, 4-(4-Dimethylamino Ethylamino)-6 methoxy quinoline, has the following structure:

Phthalamaquin



(Distributed & manufactured by the New York Quinine & Chemical Works, Inc., N. Y. C.)

This compound has both bronchial dilator and antihistaminic properties, as well as an unusual advantage of localizing in the respiratory tissues. It has been termed Phthalamaquin, and it is administered clinically either orally or intramuscularly in 50 mg. doses in the form of organic salt. The 50 per cent lethal dose for rats is 100 to 150 mg. per kg. depending upon the organic salt used. The safe chronic toxicity level is 50 mg. per kg. daily over a period of six or more weeks. In long continued clinical use the safe oral dose is 3 mg. per kg. in human beings. Assays of the antihistaminic and bronchial dilator action of the compound on the tracheal ring of guinea pigs is shown in the accompanying graphs (Figs. 1 and 2).

A series of 285 cases of bronchial asthma have been treated a year or longer with Phthalamaquin.† From the standpoint of treatment the

† All of these cases had been previously treated elsewhere by a variety of methods, and considered therapeutic failures.

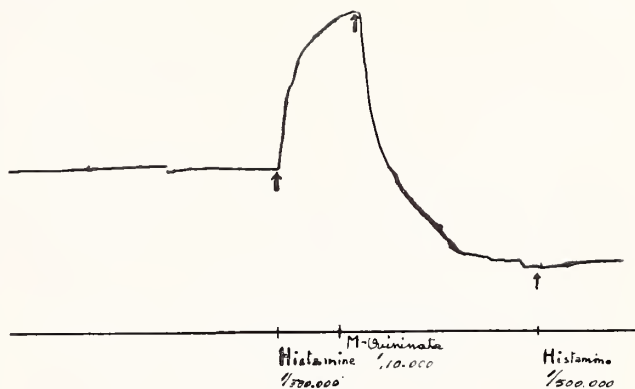


FIG. 1. Antihistaminic and bronchial dilator action of 4-(4-dimethylaminoethylamino)-6 methoxy quinoline, quinic acid salt (laboratory symbol M-quininate or MQ) on the tracheal ring of the guinea pig suspended in van Dyke-Hasting solution. The base line in front of the arrow to the left shows the normal tonus of the bronchial musculature. The upward curve from the first arrow follows the addition of histamine phosphate 1:500,000 to the physiologic bath. The second arrow shows the addition of the quinoline derivative (1:10,000) which obliterates the histamine reaction and dilates the bronchial musculature below the original base line. The third arrow shows the obliteration of the histamine response when the second dose of histamine is added.

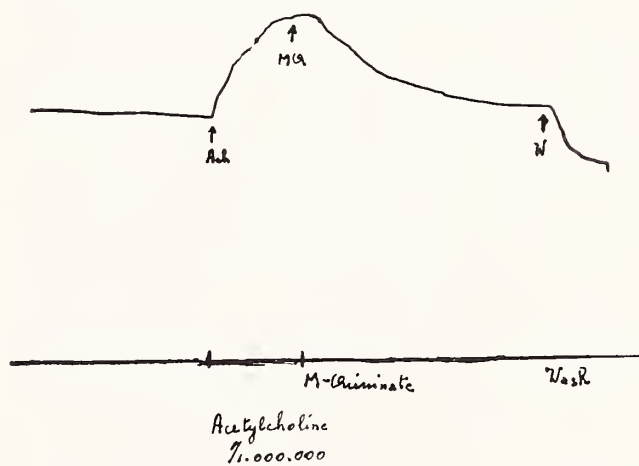


FIG. 2. Anticholinergic effect of 4-(4-dimethylaminoethylamino)-6 methoxy quinoline, quinic acid salt, on the tracheal ring of the guinea pig suspended in van Dyke-Hasting solution. The base line in front of the arrow to the left shows the normal tonus of the bronchial musculature. The upward curve from the first arrow follows the addition of acetylcholine 1:1,000,000 to the physiologic bath. The second arrow shows the addition of the quinoline derivative 1:10,000 which depresses the cholinergic response and continues to cause bronchial dilatation below the base line after the quinoline compound has been washed from the solution.

Schedule of Oral Quinoline Therapy for Control of Bronchial Asthma

	INITIAL THERAPY			MAINTENANCE THERAPY		ADD DURING ATTACK†
	Duration	Phthalamaguin	T.P.*	Continue 2 to 3 months		Aminophylline-OH
				Aureoquin	T.P.*	
Children under 4. . . .	2 weeks	3 mg./kg. q.d.	15 mg. q.d.	2 mg./kg. q.d.	15 mg. q.d.	180 mg. 1× or 2× daily
Children over 4.	3 weeks	50 mg. b.i.d.	15 mg. b.i.d.	50 mg. q.d.	15 mg. q.d.	250 mg. 1× or 2× daily
Adults†.	3 weeks	50 mg. t.i.d.	15 mg. t.i.d.	50 mg. b.i.d.	15 mg. b.i.d.	250 mg. b.i.d. or t.i.d.

* Thenylpyramine.
† Digitalize cardiacs.
‡ Injections of Phthalamaguin 150 to 250 mg. intramuscularly and give aminophylline-OH orally.

cases have been divided into 155 children, 50 young adults, and 80 adults over 40 years of age. In the juvenile group there were 2.5 per cent failures; in young adults 5 per cent failures; and in adults over 40, 10 per cent failures. About 25 per cent of the cases showed complete symptomatic remissions for periods of two to four years after therapy was discontinued. The schedule of dosage used is shown in the accompanying table.

It is important to separate the patients with bronchial asthma into the different age groups specified above. In children the chief etiological factor is upper respiratory infection. Their asthma is often mild and of brief duration and responds more readily to therapy.

In young adults, pollenosis, which requires a long latent period before it becomes clinically manifest, is a leading etiologic factor, and dosage must be regulated for the peak seasonal loads.

In adults over 40, emphysema and cardiac complications are important considerations from a therapeutic standpoint. In the present series of 80 cases of bronchial asthma in patients over 40, 75 per cent had pulmonary emphysema, and 20 per cent had cardiac complications in the form of left ventricular damage. In the cardiac cases, digitalis therapy is an important adjunct to treatment, and these patients must be evaluated by electrocardiogram, venous pressure, and circulation time.

In all cases, the quinoline derivative was combined with thenylpyramine in the ratio of 50 mg. of quinoline to 25 mg. of thenylpyramine. This therapy is administered orally as tablets or capsules two to three times daily for several months. A smaller dose is used in children under five years of age. This constituted the suppressive therapy which was responsible for the satisfactory control of the asthmatic cases treated. Improvement is usually manifested in several days to two weeks. In the event of acute attacks, the therapy was supplemented by oral or intravenous administration of a new theophylline salt, theophylline diaminopropanol. (Referred to in the table as aminophylline-OH) The aminophylline-OH is added rather than increasing the dosage of Phthalamaguin because bronchial irritation may be provoked by over-dosage with this medication.

These compounds were synthesized by Dr. Leonard Rice at the Georgetown University Medical Center in consultation with Dr. E. Emmet Reid, Professor Emeritus, Johns Hopkins University, Baltimore, Md. The bio-assays on animals were performed by Dr. Antoinette Popovici at the Georgetown University Medical Center.

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TENDON SUTURES

ERWIN R. JENNINGS, M.D.*

There are many varied sutures used in the repair of severed tendons. Because of the parallel arrangement of the tendon fibers, most tendon sutures take up a criss-cross or interweaving pattern. The type of suture used is probably not as significant as the trauma incurred to the tendon and surrounding tissues when applying the suture.

Recently a new type tendon suture was introduced in this country by Dr. George H. Yeager. The suture was originally designed by an Austrian surgeon, Dr. Fritz Lengemann. The suture in current use is a 12 inch braided tantalum wire which has a straight needle on the distal end, and a curved needle on the proximal end. Approximately 8 inches from the straight needle there is a V-shaped steel barb, which is applied in such a manner that the prongs of the barb point toward the straight needle. When suturing a severed tendon, one introduces the straight needle into the proximal segment $\frac{1}{2}$ inch from the divided end. The barb is engaged into the substance of the tendon and the straight needle then introduced through the distal segment and carried on out through the skin. Enough tension is applied to the suture to approximate the divided segments, and this tension maintained by means of a button and lead shot. The proximal portion of the suture is inserted through the skin proximally and threaded loosely through the button. After healing of the tendon, the distal button is removed, and the suture disengaged by pulling proximally. Due to the fact that this is primarily a core suture, and very little trauma is usually required for its introduction, it was postulated that this might improve the notoriously bad results characteristic with divided flexor tendons. The age old problem of severed tendons within the flexor digital sheath has presented a par-

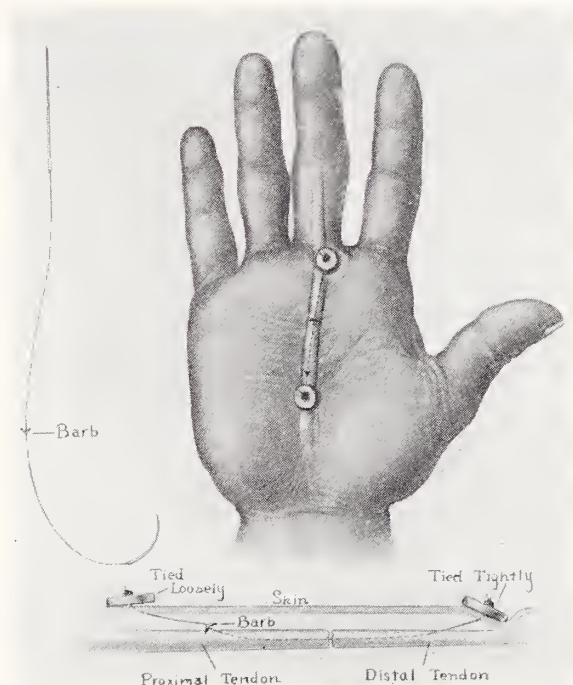


FIG. 1

ticular challenge. The results thus far obtained with 24 flexor tendons are still far from perfect (Table I). Of 16 tendons severed within the flexor digital sheath, only 8 were considered to give good results. However, of 8 tendons severed outside the flexor digital sheath, all 8 gave good results. Because of the relative ease of repairing extensor tendons, the use of this suture is not considered necessary.

The criteria for classifying results as good, fair, or poor, are based primarily on the ability or the inability to touch the distal palmar crease with the tip of the affected finger. If the

TABLE I
Results of Flexor Tendon Repair

	GOOD	FAIR	POOR	TOTAL
In Sheath.....	8	4	4	16
Not in Sheath.....	8	0	0	8
Total.....	16	4	4	24

* From the Department of Surgery, University Hospital.

distal palmar crease was approached within a distance of 1 inch, the result was considered good. If the finger was able to carry out coarse movements, with no true functional disability, and was able to approach the distal palmar crease within a distance of 2 inches, the result was considered fair. All other results were considered poor.

This series is too small to evaluate the barb wire suture in comparison to other techniques. It must suffice to say that because of the speed and ease of appliance, the over-all decrease in trauma to the tendon and surrounding tissues, this suture may prove to be a useful tool in applying the basic principles essential in hand surgery.

THE CLINICAL DIFFERENTIATION BETWEEN CARDIAC AND PULMONARY DISEASES IN RESPIRATORY FAILURE*

NORMAN M. WALL, M.D.†

CARDIAC AND PULMONARY FAILURE

The clinical differentiation between cardiac and pulmonary disease in a patient in respiratory failure can at times be extremely difficult. The diagnostic challenges are presented by patients who have had long standing respiratory disease and who are old enough to be candidates for degenerative heart disease. The problem is whether the failure is due to primary pulmonary disease or is the heart failing now as well. This question not only is extremely important for therapeutic reasons but for prognosis and for medico-legal aspects arising in compensation cases of occupational diseases.

By "clinical" differentiation is meant the facilities the physician has at hand to make a diagnosis in a moderate sized non-teaching institution. This, of course, includes routine laboratory studies, x-ray and electrocardiography. It would not include elaborate studies for pulmonary gas analysis nor the use of a physiological laboratory for detailed O₂ saturation studies, radioactive tagged ions etc. In other words with reasonable facilities available,

can one, confronted by a patient in respiratory failure, differentiate the condition as being due to the failure of the cardiac or pulmonary mechanism?

It would be well to classify briefly those respiratory diseases which cause pulmonary failure. To simplify this let us first classify those respiratory diseases which frequently cause difficulty in differentiating them from cardiac failure (Group A) and those which once diagnosed would hardly cause much of a differential problem (Group B and Group C).

Group A

1. Bronchial Asthma
2. Asthmatic Bronchitis
3. Pneumoconiosis
4. Emphysema
5. Bronchiectasis

Group B

1. Infections
 - (a) Lung abscess, tuberculosis, fungus, etc.
2. Neoplasms
3. Mechanical Obstructions
 - (a) Foreign bodies
 - (b) Mediastinal masses; lymphadenopathy; aneurysms, etc.

* Presented before the Allegany-Garrett County Medical Society, November 21, 1952, Cumberland, Md.

† From the Department of Internal Medicine, Good Samaritan Hospital, Pottsville, Pa.

Group C

1. Respiratory neurosis

Before attempting a differentiation one should have an adequate concept of heart failure. It is not the purpose of this report to discuss the etiology of heart failure. Authorities are far from agreement as to the exact pathogenesis of failure. Some feel the primary etiological site may not even be in the heart but in the kidneys or adrenals or in the pituitary-adrenal axis etc. However, we do know that in cardiac failure there is fluid in the extracellular spaces that should not be there.

The respiratory tract assumes the most prominent position in heart failure. Early evidences of failure begin here and persist with increasing severity till the patient expires from pulmonary edema. The very first symptom of heart failure is breathlessness. If the left ventricle weakens and pumps out less blood than the right ventricle pumps in, then pulmonary congestion ensues and dyspnea starts. This is seen mostly in hypertensive and coronary artery disease.

Paroxysmal dyspnea is the key episode confronting the physician in the differentiation of respiratory failure. This nearly always occurs in bed in both cardiac failure and in the asthmatic paroxysms of respiratory disease. There is a fairly sound physiological reason why nocturnal dyspnea due to left ventricular failure occurs. Lying down facilitates a slight gradual shift of fluid from the periphery to the pulmonary circuit. Venous return from the legs is enhanced and the blood volume increases. These factors increase the return to the left auricle, which now expels a little more blood into an already weakened left ventricle and the latter promptly fails. In addition sensory perception is diminished during sleep and reflex stimuli from congested lungs, which are extremely important in clearing the pulmonary bed, are less effective during sleep. Finally after an excessive accumulation has occurred in the lungs the respiratory center will respond vigorously to stimuli. This

results in laborious breathing with slight or marked pulmonary edema. The accompanying cough will only aggravate further the vicious cycle of pulmonary distress. There is only one effective way of blocking this vicious cycle of bombarding stimuli and that is by morphine. Other disturbing stimuli which occur at night that may set off such a chain reaction are a full bladder, abdominal distention and unpleasant dreams. These neurogenic cycles are nearly always effectively broken by morphine and it is for this reason that morphine is so valuable in severe paroxysmal dyspnea.

With right sided failure the right ventricle can not expel efficiently all the blood that it was meant to handle, as evidenced by the early increase of venous pressure. This is most often seen in mitral stenosis. Engorgement of the neck veins occurs as well as hepatic congestion, visceral congestion and dependent edema. With hepatic and visceral engorgement, epigastric distress, right upper quadrant pain and marked digestive disturbances can occur. In the late stages ascites develops, causing considerable difficulty. Significant venous and visceral engorgement can occur in ambulatory patients without edema because the muscle action of the legs efficiently "pumps" blood back up toward the heart. Rarely does one sided failure exist in pure form; the combination is nearly always seen.

Insofar as the physical examination of the heart is concerned there are only a few significant findings to indicate failure. The presence of a diastolic gallop rhythm or a pulsus alternans generally indicates failure. An accentuated P_2 signifies increased pulmonary pressure but this varies with the observer. Cardiac enlargement with all the above signs and symptoms is the "sine qua non" of heart failure. However, murmurs, irregular rhythm and cardiac enlargement alone do not indicate the presence of heart failure.

The most significant factors in determining cardiac failure are a few objective procedures.

These are not complex and are easily interpreted and extremely important.

1. *The Vital Capacity Determination:* This is easily done with a spirometer. Normally the average adult has a total breathing space of about 4000 cc. and inhales 400 cc.-500 cc. with each breath and on effort can increase the rate and depth of respiration without distress. If his vital capacity is reduced it is easily detected with a spirometer.

2. *Venous Pressure Determination:* This is determined with a manometer connected to an antecubital vein by a 20 gauge needle. Normal values are 400 mm.-80 mm. of water. This test is extremely important in doubtful cases of congestive failure.

3. *Circulation Time:* The velocity of blood flow can be determined by injecting a testing solution into an antecubital vein. Its arrival at the tongue is signaled by the unique taste of the substance. Such solutions are Decolin 3 cc. to 5 cc. of 20% solution; end point bitter; 2 Gm. to 3 Gm. of Saccharin in distilled water; end point sweet; Calcium Gluconate (2.5 cc. 20% solution); end point is warmth. Caution should be used in digitalized patients because of synergistic action of calcium and digitalis. In testing, the patient should be recumbent; the injections rapid and the end point accurately timed by a stop watch. Normally the end point is about 15 seconds; in marked congestion it may be 25 to 50 seconds.

4. *Blood Volume:* Normal volume is about 5000 cc. In failure it may increase to 6-7 liters. This is one of the most constant changes that accompany heart failure. Excess blood is stored in the venous circulation, the lung, and to some extent in the dilated heart. The test is relatively simple when carried out by the dye absorption method. This is similar to a Bromsulphthalein liver function test. A measured quantity of dye is injected intravenously and the dilution is determined.

5. *Chest X-ray:* The P.A. view of the chest in significant heart failure will show pulmonary

congestion and an enlarged heart. Pulmonary congestion is first demonstrated by a "sun-ray" pattern of increased bronchial markings, extending from the hilar area. Cardiac enlargement is usually obvious to the eye but can be measured. There are measures based on mass and density for heart measurement; but if there is equivocation, these measurements are of little value in making a positive diagnosis of heart failure.

With the recognition of heart failure and its objective determination we can now return to the respiratory diseases that cause pulmonary failure. In all of these we are considering respiratory diseases that are long standing. Therefore, patients for this consideration will range from the 4th decade on.

BRONCHIAL ASTHMA

It is unnecessary to describe the clinical picture of the patient with classical bronchial asthma. He is one with a long standing allergic background, sensitive to inhalants and now condemned to a life of emphysema. The bellows action of his chest cage is practically nil, his exchange of tidal air in his lungs is minimal and he sits up in an orthopneic position; his neck sunk into the thoracic cage. How do we know he is not in cardiac failure? Obviously his vital capacity is low, he is cyanotic, orthopneic and dyspneic but he is not in cardiac failure if he fulfills the following criteria: An x-ray of the chest showing a normal or frequently a small heart in addition to extensive emphysema. Circulation time and venous pressure normal along with a normal blood volume. No venous engorgement; the liver not enlarged and no dependent edema.

The electrocardiogram, which can never be interpreted as indicating heart failure can, however, indicate the presence of a damaged heart. Respiratory distress in cardiac decompensation is on the basis of left ventricular failure. The most common causes of left ventricular failure are hypertension and coronary artery disease.

When these conditions are sufficiently severe to cause heart failure they practically always will be accompanied by an abnormal electrocardiogram. A normal electrocardiogram in severe dyspnea would be added evidence that the dyspnea is not on a cardiac basis.

The clinical picture of the chronic asthmatic with emphysema differs little from that of the patient with asthmatic bronchitis, pneumoconiosis, emphysema or bronchiectasis. Actually asthmatic bronchitis may be considered with the old classification of intrinsic asthma. He is the patient who has had chronic respiratory infection for years and finally develops emphysema and asthma.

BRONCHIECTASIS

The patient with bronchiectasis who has gone into chronic pulmonary failure can be recognized by his general debility, and copious sputum that is frothy and may be in layers. His past medical history is marked with frequent episodes of respiratory tract infection, sinusitis, pharyngitis, bronchitis, etc. The bronchiectatic frequently has pulmonary arthropathy which is lacking in even the most severe of the other cases in Group A. If he is in pure pulmonary failure, although he will be severely dyspneic and cyanotic he will not necessarily be orthopneic and will have no venous engorgement, hepatic enlargement or edema. Three of the four objective findings (Venous Pressure, Circulation Time and Blood Volume) for cardiac failure will be normal. His electrocardiogram may well be normal and the clinching factor will be the chest x-ray. Bronchogram will nicely demonstrate the bronchiectatic areas and the heart size will be normal.

EMPHYSEMA WITH ANTHRACOSILICOSIS

Pure emphysema is not a common occurrence but it is extremely frequent as a complication of chronic respiratory diseases. A clinical combination is emphysema with pneumoconiosis and the two can be discussed as a clinical entity.

Because of our locale we shall select anthracosilicosis as our best example. The anthracosilicotic in respiratory failure presents a uniformly characteristic picture. His medical history is suggested by his pasty gray, sunken, apathetic countenance tattooed with the tell-tale blue marks of mine explosions. In spite of the marked decrease in vital capacity with severe dyspnea, we have frequently observed these miners to be free of orthopnea. Further differentials of these cases from cardiac failure include lack of venous engorgement, and lack of both liver enlargement, and dependent edema. The three objective tests for heart failure (see above) will be normal. The clinching diagnosis again in these cases is the chest x-ray. Here one sees the nodulations of silicosis ranging from small coalescences to massive nodules almost as big as baseballs. The remaining lung fields are extensively emphysematous. The cardiac silhouette will be normal or frequently small in size. If the electrocardiogram is normal this is further evidence of lack of cardiac involvement. However, it is possible that these older miners may show some electrocardiographic evidence of coronary disease; but if all the above objectives tests for heart failure are normal and if the heart size by x-ray is normal, then in spite of abnormal electrocardiogram one can state categorically these patients are not in congestive failure. The importance of the medico-legal aspects of this in compensation cases of occupational diseases is obvious.

There is rarely difficulty in differentiating cardiac failure from pulmonary failure due to diseases in Group B. Roentgenograms of the chest and laboratory findings quickly identify the etiology; furthermore chronic long standing cases rarely occur because of the limits set by the disease entities.

Group C can be divided into 3 categories:

1. The neurasthenic: This is usually a female, who has non-descript constant chest pain associated with a sighing type of respiration resembling dyspnea. Usually these symptoms

develop from close association with a relative or friend who has organic heart disease. Objective tests, of course, show an excellent vital capacity with all other tests normal.

2. The obese, dyspneic female with puffy ankles: She has probably been told by a physician at one time or another that she has a "bad heart" and even was hospitalized. The objective tests will all prove to be normal. Her problem, of course, is one of reassurance and weight reduction.

3. The hysteric: This patient, usually a female, may be so profoundly disturbed that her dyspnea develops into an over ventilating alkalosis and she actually incapacitates herself. Her objective cardiac tests will all be normal and she may be reassured by this or psychotherapeutic measures.

COR PULMONALE

When after years of pumping against a resistant pulmonary bed in patients with chronic pulmonary diseases, the right ventricle fails and failure associated with Cor Pulmonale may develop. This is diagnosed by finding abnormal objective tests for failure. The chest x-ray will show prominence of the right side of the heart and the electrocardiogram frequently will show a right ventricular preponderance.

MANAGEMENT OF CONGESTIVE HEART FAILURE

In pursuing the differential diagnosis of congestive heart failure from pulmonary failure the management of these conditions becomes an integral part of the picture. It is not the intention of this paper to give detailed therapy of all the diseases mentioned, but a comprehensive discussion of therapeutic management should be of differential value.

Bed Rest: This is of great importance but a flexible interpretation of bed rest is necessary. For example, patients with marked pulmonary congestion would do well to sit on a chair for the greater part of the day. "Water in the feet is unsightly but water in the lung will kill."

More liberal use of bathroom privileges should always be considered where indicated.

Sedation: Phenobarbital and bromides are of great value and morphine, as explained above in paroxysmal dyspnea, is of utmost necessity.

Diet: Suffice it to say that a low sodium diet has been proven of significant value in cardiac failure. It is improbable that one can obtain a daily sodium intake under 1 Gm. The value of a low caloric diet in a patient with a weakened myocardium is obvious.

Oxygen: Oxygen by mask in acute failure can be most effective. Overlooked frequently in patients with chronic failure is the fact that patients who are home and ambulatory or even doing light work may benefit immeasurably by oxygen administered as needed.

Digitalis: There is one universal indication for digitalis and that is congestive failure. In acute failure one should use the most rapid glycosides such as digoxin intravenously if necessary for it may prove life saving. As for chronic failure one should use the type of digitalis with which he is most familiar. Either digitoxin or the powdered leaf is effective.

Diuretics: With the patient on a low sodium diet the use of a mercurial diuretic intramuscularly or intravenously can produce a most gratifying type of diuresis. In fact if properly administered some authorities feel that a mercurial diuretic is the most important drug in the medical armamentarium for congestive failure. It is our feeling that oral diuretics are of no significant value. Ammonium chloride can be used to enhance the activity of the mercurial diuretic. With copious and frequent diureses one must be on guard against the salt depletion syndrome.

Aminophyllin: This is one of the most valuable drugs available for patients with cardiac failure who have respiratory symptoms. The patient who suffers at night with dyspnea can very often assure himself a comfortable night by the insertion of an aminophyllin suppository (0.5 gram). For the critically ill patients who have

early pulmonary edema a slow intravenous drip of 0.5 Gm. of aminophyllin in distilled water may be of great value. For the patient with severe paroxysms of cough and dyspnea, aminophyllin orally is of no value.

Phlebotomy: In acute pulmonary edema a situation will occasionally arise when a phlebotomy will be the only procedure that can be performed but it may be dramatically life saving. To be effective it should be done very rapidly. As large a needle as possible should be used and the entire amount of blood (400 cc.-700 cc. depending on the size of the patient) should be withdrawn in about 10 minutes.

Other Drugs: Quinidine, anti-coagulants, and anti-biotics etc. are used in failure when specifically indicated.

Mechanical Methods: Bloodless phlebotomies and Southey tubes are used rarely in some intractable cases of failure. Paracentesis of the chest and abdomen is, of course, done in advanced cases when indicated.

Differential Diagnosis in Therapeutic Consideration: With the above management of cardiac failure in mind let us return to the respiratory diseases in Group A.

BRONCHIAL ASTHMA

Measures such as rest, oxygen and sedation are indicated in bronchial asthma. A salt poor low caloric diet, however, would actually be contraindicated in an asthmatic who should have a good saline intake and a very nutritious diet. For the patient in a protracted seige of asthma the most valuable therapy is epinephrine and ACTH or cortisone. The use of these drugs in a mistaken case of heart failure would be tragic. The danger of epinephrine in an already weakened myocardium or in a hypertensive is obvious. One of the prime contraindications of ACTH and cortisone is heart failure because of the great tendency these drugs have for binding water and causing edema.

It has long been known that morphine in a case of intractable bronchial asthma can on

occasion be fatal. A phlebotomy would only aggravate the weakness of an already badly exhausted asthmatic. Digitalis and mercurials would have no value in these cases. They could be toxic in indiscriminate usage. It is extremely important to differentiate between these two types of respiratory failure.

PNEUMONOCOINOSIS WITH EMPHYSEMA

The management of these cases differ radically from that of heart failure. With the exception of aminophyllin and antibiotics none of the above cardiac therapeutic measures is used. The keystone of therapy is to reduce infection and encourage bellows action of the lungs. Prolonged use of antibiotics such as penicillin combined with iodides facilitates bronchial drainage. Guided breathing exercise with abdominal support encourages bellows action of the lungs. The administration of oxygen under positive pressure is being tried on anthracosilicosis but its value is still in doubt. When these patients develop bronchospasm, aminophyllin as used for congestive failure is of great value.

The management of bronchiectasis again differs radically from congestive failure management. Mistakenly treating a bronchiectatic with congestive failure measures would soon doom the patient. The management of bronchiectasis very briefly consists of three measures: (1) combat infections, (2) drainage and (3) surgery.

SUMMARY

The clinical differentiation between cardiac and pulmonary disease in respiratory failure is outlined. This challenging problem arises frequently and has many medical and non-medical implications. The differential is based mainly on relatively simple but important objective findings with symptomatic evaluation. Therapy is discussed in order to emphasize the extreme importance of making a proper diagnosis. The therapy of one disease mistakenly applied to another can not only be unfortunate, but tragic.

FULMINATING THROMBOPHLEBITIS MIGRANS

WILLIAM F. RENNER, M.D.^{1, 2}

Thrombosis and its complications constitute the most common mechanism of death in the older age group. Yet the pathogenesis of thrombosis remains poorly understood, although many of the predisposing factors are recognized. Change in the walls of blood vessels is a common antecedent factor to thrombosis. This factor operates in atherosclerosis, in thromboangiitis obliterans, and in septic thrombophlebitis. Changes in the constituents of the blood are thought to play a role in some cases of thrombosis. This is true in thrombosis associated with evidence of hypercoagulability, with the phenomenon of sludging, and with increased platelet adhesiveness.^{1, 2, 10} In cryoglobulinemia and in the syndrome of cold hemagglutinins, the cells of the blood agglomerate so as to obstruct the vessels and interfere with blood flow, a phenomenon very similar to thrombosis although the mechanism involved is probably fundamentally different.^{1, 2, 3}

The factor of stasis is well recognized and is known to play a role in the tendency to thrombosis in patients confined to bed and in congestive heart failure. Malignancy, particularly of the pancreas, may first manifest itself through a migratory thrombophlebitis. However, patients with a pronounced tendency to thrombosis are quite commonly seen in whom no abnormality of the blood and no systemic disease can be found to account for the thrombosing tendency. Familial thrombophilia and idiopathic thrombophlebitis migrans fall into this category. Cases of acute thrombophlebitis in young, ambulant, apparently healthy individuals are no longer considered a rarity.^{4, 5}

The subject of this report, while in apparently good health except for a moderately severe arterial hypertension, developed a remarkable acute thrombosing tendency which proceeded rapidly to a fatal termination. Despite therapy, a symmetrical gangrene of the lower extremities developed with evidence of involvement of an upper extremity and of the brain by the thrombotic process. The clinical course and pathological examination of one of the digits indicated that both arterial and venous systems were involved in the thrombophilia. The case is of particular interest because of the evidence of arterial involvement which is in contrast to previous otherwise similar case reports of thrombophlebitis associated with gangrene in which the gangrene appeared to be due to extensive venous thrombosis without organic arterial occlusion.

CASE REPORT

The patient, a 70 year old white woman, had enjoyed good health except for a moderately severe asymptomatic arterial hypertension. She gave a history of having "bruised easily" but otherwise had never exhibited abnormal bleeding. In other respects the past history was not remarkable.

On April 15, 1953, she presented herself complaining of multiple painful nodules on both legs of two weeks duration. These nodules had the typical appearance of a superficial thrombophlebitis. Thrombi could be palpated in the veins. The overlying skin was red and of increased temperature. Slight varicosities were present bilaterally. Arterial pulsations were normal. There was no evidence of deep vein involvement. The patient was advised to remain in bed with elevation of the legs. She was given aureomycin for four days because of the possibility of a recent upper respiratory infection playing an excitant role in the phlebitis. At the

¹ Union Memorial Hospital, Baltimore, Maryland.

² The author wishes to acknowledge the assistance of Walter Merkel, M.D., Pathologist, The Union Memorial Hospital and Jesse Hubbard, M.D., Resident in Pathology, The Union Memorial Hospital.

end of that time the phlebitis appeared to be subsiding. Then new areas of phlebitis appeared and ankle edema developed. On May 4, two weeks after the patient was first seen, there was sudden onset of pain in the right chest, aggravated by respiration. Moist râles were noted at the right base for the first time. A diagnosis of pulmonary embolism was made, and the patient was promptly hospitalized.

On admission to hospital, temperature was 100° F., pulse 90, and the blood pressure 138 systolic and 84 diastolic. Moist râles were again noted at the right base. The left leg was considerably swollen with marked calf tenderness. The right leg was slightly swollen but not tender. The physical examination was otherwise not remarkable. Clotting time was 4'30" (capillary tube method). Bleeding time was 30". Hemoglobin level was 79.4% (11.5 Gm., Wintrobe). W.B.C. 9,900. Urinalysis normal. N.P.N. 35.5 mg. per 100 cc. Fasting blood sugar was 93 mg. per 100 cc. Platelet count 120,000. Alkaline phosphatase was 8 Bodansky units. Cephalin flocculation was reported as a trace in 24 hours. The serologic test for syphilis (blood) was negative. Except for a few days after the occurrence of the pulmonary embolism and a few days terminally, the patient was afebrile.

Therapy with heparin and dicumarol was initiated on the day of admission. Over a period of two weeks, the patient appeared to be gradually improving although new evidence of phlebitis continued to develop. Two weeks after admission, the patient developed severe pain in the left leg and foot and the left leg became extremely swollen from the knee down. During the course of the next 24 hours, a severe bluish discoloration of the distal portion of the foot and of the toes developed, with coolness of the skin. The distribution of the discoloration was patchy. The 3rd and 4th toes were most discolored, the 1st and 5th toes to a lesser extent. The 1st toe was involved in its proximal portion, the distal portion remaining quite pink and warm throughout the illness. The patchy dis-

tribution of cyanosis and the normal appearance of the distal portions of some of the toes was interpreted as indicating that if the arterial side of the vascular tree was being occluded small end vessels were undergoing thrombosis since characteristically occlusion of the main artery to a part causes severe ischemia in the distal portion of the part affected. It is to be noted that the pathological report, to be described below, supported such an interpretation. The severe edema nullified attempts to palpate the peripheral pulses.

The patient ran a rapidly downhill course. Vigorous effort was made to keep the prothrombin time within therapeutic range. When indicated, supplementary doses of heparin were given. Priscoline was administered parenterally. As the course continued downhill, therapy with ACTH was initiated in view of favorable reports in the literature of the effect of ACTH on the course of migratory phlebitis.

The left foot rapidly developed a superficial gangrene. The skin broke down in several areas and drained a sanguineous material. Six days after the discoloration first appeared in the left foot, the distal segment of the right foot became cool and painful and discolored. The discoloration proceeded rapidly to gangrene. The gangrene of the two feet had a remarkable symmetry of distribution. On May 25 a hemiplegia of the left side of the body developed in a manner suggesting a cerebral thrombosis. Two days later, deep cyanosis of the 3rd and 4th fingers of the right hand appeared. There was no swelling of the fingers and no prominence of the veins, suggesting that the cyanosis was purely arterial in origin. Two days later the patient expired.

POSTMORTEM EXAMINATION

Unfortunately the autopsy was restricted to examination of one of the involved toes. The following is quoted from the microscopic description of sections of this toe. "The sections are characterized by an enormous dilatation of the vascular channels, including the capillaries.

The venules are distended to capacity, indicating apparently an obstruction to the venous side, because of the enormous dilatation and stemming back of the blood. The wall of a small artery is eccentrically thickened and the lumen is occluded by freshly clotted blood. Some of the venules show thrombi and along a few of these are an unusual number of leukocytes, and these are seen along the outer surface of the vessel, apparently not settled out by the stagnant blood."

COMMENT

Gangrene is a rare complication of thrombophlebitis. Haimonici, in an extensive review of the literature up to 1949, was able to collect only 28 cases of gangrene of an extremity secondary to venous thrombosis.⁶ Since this time at least four additional cases have been reported.^{7, 8, 9} The consensus of opinion regarding the mechanism of the gangrene in these cases has been that the massive venous thrombosis, involving both the main venous channels and the small tributaries, resulted in an ischemia of sufficient degree to lead to necrosis. This opinion has been based on the invariable absence of evidence of arterial occlusion in the specimens which were submitted to pathological examination. Some authors have felt that arteriospasm played a subsidiary role in the mechanism of the gangrene, but the general opinion has been that spasm of the arteries, if present at all, was of very little importance. In the case described above, there is clear evidence of arterial involvement. After gangrene developed in the lower extremities, two fingers of the right hand became cold and deeply cyanotic and undoubtedly would have gone on to gangrene had death not intervened. Late in the illness the patient developed a left-sided hemiplegia suggesting cerebral thrombosis. Post-mortem examination of one of the digits showed thrombosis of a small artery.

The question arises as to the proper classification of the disease which took this patient's life.

Thrombophlebitis is obviously an unsatisfactory term since it does not take into account the arterial thromboses. Thromboangiitis obliterans is a disease which is characterized by both thrombophlebitis migrans and arterial occlusion. However, the age and sex of the patient, the clinical course, and the absence of characteristic pathological changes make this diagnosis untenable. Thrombophilia, either essential or secondary to a hidden malignancy which might have been found had a complete autopsy been possible, would be an appropriate diagnosis were it not for the fact that this term has already been used by Nygaard and Brown to designate a thrombosing tendency associated with evidence of hypercoagulability, a condition which was not demonstrated to be present in this case.¹¹

For want of a better diagnostic term in the current classification of diseases and in consideration of the fact that a migratory phlebitis was the outstanding feature, the case is considered as one of thrombophlebitis migrans of unknown etiology, complicated by arterial thromboses and by gangrene of the lower extremities. It is thought that venous and arterial thromboses played synergistic roles in the production of the gangrene.

SUMMARY

A case of fatal fulminating thrombophlebitis migrans with symmetrical gangrene of the lower extremities in an elderly female is presented. During the course of the illness evidence developed of organic arterial occlusion in the lower extremities, one upper extremity, and the brain, indicating that the thrombosing tendency involved both the arterial and venous systems. No abnormality of the blood clotting mechanism to account for the thrombosing tendency was detected.

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DRS. MARTIN AND CROSBY ON HOOVER COMMISSION'S MEDICAL TASK FORCE

The AMA Washington Letter, No. 44

Two physicians well known to the medical profession, Dr. Edwin L. Crosby and Dr. Walter B. Martin, have been appointed to the Hoover Commission's Medical Task Force. The Force will study all medical activities conducted by branches of the federal government. Membership will include physicians prominent in medical school activities, in public health work, and in research. Invitations have gone out to the full panel, but at the Commission's Washington headquarters it was said their names would not be announced officially until letters of acceptance have been received.

Dr. Martin, president-elect of the AMA, has been active in association work for many years. He is in private practice at Norfolk, Va.

Dr. Crosby, research director for the Task Force, is director of the Joint Committee on Accreditation of Hospitals, with headquarters in Chicago. The committee is supported by AMA and the American Association of Medical Colleges. Dr. Crosby is the immediate past president of the American Hospital Association. He expects to divide his time between the Task Force and the accreditation committee. Under commission procedure, Task Forces may hire their own staffs and set up headquarters in any city the members find convenient.

Chairman of the Medical Task Force will be Mr. Chauncey McCormick of Chicago, an associate of Mr. Hoover in European rehabilitation work following World War I. He has been active in organizations concerned with blindness, child care, and welfare problems.

HEALTH GRANTS TO CONTINUE, ROCKEFELLER TELLS HEALTH OFFICERS

THE AMA Washington Letter, No. 45

Undersecretary Nelson Rockefeller, addressing state and territorial health officers at their 52nd annual conference with federal health officials on November 5, declared: "Let me state categorically that grants to health activities will continue." The issue, he said, is how a given function "can best be performed and supported." The No. 2 official in the Department of Health, Education, and Welfare made these additional points: (1) in the poorest states with the greatest health needs, the nation as a whole has a responsibility, (2) the government should provide special aid to unique projects such as migratory labor groups, (3) technical and professional aid to states will be continued, and (4) the federal-state partnership should have the motto: "Maximum opportunity for state decision and minimum federal control."

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

At a recent meeting of the Allegany-Garrett County Medical Society, Dr. William K. Diehl, Professor of Gynecology at the University of Maryland discussed "Functional Uterine Bleeding." Dr. Diehl's talk was illustrated with lantern slides.

The Allegany County Health Department has announced the discontinuance of the night clinic.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

The Committee on Emergency Medical Calls has met periodically. The system seems to be running quite smoothly. There is a need for additional

physicians to sign up. Any members of the Society who can see their way clear to help out, even for a month or so, should see the Chairman of the Committee, Dr. Paul E. Carliner, and arrange to be put on the rosters.

A TV closed circuit broadcast in November was much enjoyed by those who saw it. The length of the show aroused some discussion and it is probable that a second one, if it can be arranged, will be briefer.

Postgraduate courses will be underway and a copy of the program will be mailed to each member. Members of the Medical and Chirurgical Faculty are cordially invited and urged to attend these courses, regardless of whether membership is in the Baltimore City Medical Society or one of the County Societies. President Gundry intends to follow the schedule of courses as developed by the Committee and wants it understood that suggestions are always welcome.

The detailed program of the postgraduate courses is as follows:

DERMATOLOGY

All sessions will be held in the early afternoon.

Tuesday, January 5, 1954

	University of Maryland School of Medicine CHEMICAL HALL	
12:00 noon	Briefing session on all courses. University Hospital OUT-PATIENT DEPARTMENT	H. M. Robinson, Jr., M.D.
12:10 p.m.	Clinical Demonstration. University of Maryland School of Medicine CHEMICAL HALL	H. M. Robinson, Sr., M.D., and Staff
1:00 p.m.	Infant Eczema.	H. M. Robinson, Sr., M.D.
1:15 p.m.	Superficial Mycoses.	Eugene S. Bereston, M.D.
1:30 p.m.	Psoriasis.	Israel Zeligman, M.D.
1:45 p.m.	The Acne Problem.	H. M. Robinson, Jr., M.D.
2:00 p.m.	Simple Office Procedure for Demonstration of Fungi.	Morris M. Cohen, M.D.

Tuesday, January 12, 1954

	The Johns Hopkins Hospital HURD HALL	
2:00 p.m.	Lecture Demonstration. Benign and Malignant Neoplasms of the Skin	Lloyd W. Ketron, M.D., and Maurice Sullivan, M.D.

Tuesday, January 19, 1954

University Hospital
OUT-PATIENT DEPARTMENT

12:00 noon	Clinical Demonstration.	H. M. Robinson, Sr., M.D., and Staff
1:00 p.m.	Effect of Emotions on the Skin.	Mark Hollander, M.D.
1:15 p.m.	Contact Dermatitis.	Albert Shapiro, M.D.
1:30 p.m.	Occupational Dermatoses.	R. C. V. Robinson, M.D.
1:45 p.m.	Lupus Erythematosus.	William R. Bundick, M.D.
2:00 p.m.	Parasitic Diseases.	David Bacharach, M.D.

Tuesday, January 26, 1954

The Johns Hopkins Hospital
HURD HALL

2:00 p.m.	Review of General Principles of Topical Therapy of Dermatitis or Eczema.	H. Hanford Hopkins, M.D.
3:00 p.m.	Seborrheic Dermatitis.	Leon Ginsburg, M.D.

Tuesday, January 28, 1954

University Hospital
OUT-PATIENT DEPARTMENT

12:00 noon	Clinical Demonstration.	H. M. Robinson, Sr., M.D., and Staff
	University of Maryland School of Medicine CHEMICAL HALL	
1:00 p.m.	Panel Discussion. Members of Panel will answer questions proposed by attending physicians on diagnosis and treatment of dermatoses.	

HEMATOLOGY

NEW CLASS ROOM—THE JOHNS HOPKINS HOSPITAL

Wednesday Evenings, 7:30 to 9:30 p.m.

1954		
February 3	Diagnosis and Treatment of Anaemias.	C. Lockard Conley, M.D.
February 10	Leukemias and Lymphomas.	Milton S. Sacks, M.D., and Staff
February 17	Hemorrhagic Disorders.	Dudley P. Jackson, M.D.
February 24	Blood Groups, Immunology, including Erythroblastosis and Transfusion Problems.	Milton S. Sacks, M.D., and Staff

ENDOCRINOLOGY

HURD HALL—THE JOHNS HOPKINS HOSPITAL

Thursday Evenings, 8:30 p.m.

1954		
March 4	Disorders of the Pituitary Gonads.	H. F. Klinefelter, Jr., M.D.
March 11	Disorders of the Pancreas.	T. Nelson Carey, M.D.
March 18	Disorders of the Adrenals.	John Eager Howard, M.D.

Wednesday Evening, 8:30 p.m.

March 24	Disorders of the Thyroid.	Samuel P. Asper, Jr., M.D.
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DISTURBANCE OF WATER AND ELECTROLYTE METABOLISM

NEW CLASS ROOM—THE JOHNS HOPKINS HOSPITAL

Thursday Evenings, 8:00 p.m.

1954		
April 1	Some Physiological Background to Problems in Water and Electrolyte Metabolism.	J. L. Lilienthal, Jr., M.D.
April 8	Mechanisms and Treatment of Water and Electrolyte Disturbances in Medicine.	Kenneth L. Zierler, M.D.
April 15	Water and Electrolyte Disturbances in Pediatrics and in Diseases of the Nervous System.	Harold E. Harrison, M.D.
April 22	Water and Electrolyte Disturbances in Surgery.	Eric Nanson, M.D.

MONTGOMERY COUNTY MEDICAL SOCIETY

CHARLES I. WARFIELD, M.D.

Journal Representative

On December 15 at Woodmont Country Club, the Montgomery County Medical Society celebrated its 50th Anniversary with a dinner and dance. The highlight of the evening was an address by Governor McKeldin of Maryland. Also present were U.S. Senator Hyde and Congressman Beall of Maryland; and other honored guests.

Governor McKeldin and Dr. C. Warfield, Chairman of the Public Relations Committee of the County Society, appeared on the Mark Evans T. V. Show, previous to attending the affair at Woodmont. The event was carried in all metropolitan newspapers and by all local radio stations.

The Montgomery County Medical Bureau which is sponsored by the County Medical Society has just successfully completed its first year in operation. The Emergency Call System of the Montgomery County Medical Society and Medical Bureau has received wide spread national publicity, including an article in Medical Economics. Several State and County Societies have since adopted identical or similar programs.

WASHINGTON COUNTY MEDICAL SOCIETY

OMAR D. SPRECHER, JR., M.D.

Journal Representative

The third regular quarterly meeting of the Washington County Medical Society was held at the Alexander Hotel.

Thomas McPherson Brown, M.D. Prof. of Medicine, George Washington School of Medicine, Washington, D. C., was the principal speaker, on the subject "*A Concept of the Basic Mechanisms and Management of Rheumatic Diseases and Arthritis.*" This was a very interesting and well-presented discussion, based on his research and clinical experience over many years. The clinical results obtained have not been over a long enough period of time, as yet, for final evaluation.

Dr. John M. Welch (Col. U.S.A. (Ret.)) Chief of Medical Services, Maryland Civil Defense, gave a brief review of progress in organization, anticipated number of casualties in event of Atomic Attack, and pointed out the necessity for 100% Cooperation of the Medical profession in the organization. Dr. Ernest F. Poole, Chief of Medical Service, Washington County Civil Defense, was complimented on the structural organization, completed here to date.

Officers were elected for the coming year as follows:—

President:—Archie R. Cohen

Vice-President:—S. Earl Young

Sect. & Treas.:—Ernest F. Poole

A textbook on Surgery was presented to the Washington County Hospital Staff Library in memory of the late Dr. Daniel A. Watkins, one of the early surgeons at the hospital, and Emeritus Member of the Washington County Medical Society.

DR. FRANK BERRY TO SUCCEED DR. CASBERG

The AMA Washington Letter, No. 45

Shortly after the first of the year Dr. Frank Brown Berry, a New York surgeon with military service in two World Wars, will succeed Dr. Melvin A. Casberg as Assistant Secretary of Defense for health and medical affairs. Dr. Berry, professor of clinical surgery at Columbia University Medical School, holds the rank of brigadier general, retired; in the last war he headed the 9th Evacuation Hospital in various parts of Europe. Dr. Berry will be the top ranking medical official in Defense Department, responsible for operation and coordination of Army, Navy, and Air Force medicine. Dr. Casberg is returning to private practice in Solvang, California.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

INFLUENZA

LOUIS KRAUSE, M.D.*

A scourge that has visited mankind over the ages, its origin and epidemiology for the most part is one of conjecture. History indicated its probable recurrence every several decades leaving a heavy toll in its wake. There is some reason to believe that it visited our own New England shores in 1617 and 1619, just a few years before the Pilgrims landed; and their records showed the frequency of Indian villages being wiped out and great numbers of

* Chairman, Library Committee.

skeletons found in the woods with no evidence of death from trauma, suggesting again the possibility that an influenza epidemic had visited the place. It may be that this accounted for the lack of resistance offered the early settlers in landing in America. It is true that often, disease will foil armies and alter the events of history.

Many of us remember the epidemic of 1918; and the terrible death toll, particularly amongst the apparently very healthy young folks both in civil life and in the army at that time. In all likelihood, it will follow its cycle and perhaps recur again.

Appended is a list of books in the Library on old and recent knowledge on this threatening epidemic

BOOKS ON INFLUENZA IN THE MEDICAL AND CHIRURGICAL FACULTY LIBRARY

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FACULTY MEMBERS!

If the parking situation keeps you from using the library as much as you wish, remember you can park in the lot behind the Faculty Building until five o'clock. Entrance on Maryland Avenue.

A SELECTED LIST OF PUBLICATIONS RECENTLY ADDED TO THE LIBRARY

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- U. S. Department of Health, etc. Directory of state & territorial health authorities. Govt. Print. Off., 1953.
- Willis, R. A. Pathology of tumors. St. Louis, Mosby, 1953.
- Yearbook of general surgery. 1953-54 series. Chic., Yearbk., 1953.
- Yearbook of obstetrics and gynecology. Chic., Yearbk., 1953.

NEW SUBSCRIPTIONS

Subscriptions to the following periodicals have been entered, to begin with January 1954.

ANNALS OF THE RHEUMATIC DISEASES
 BIOCHEMICAL JOURNAL
 BRITISH JOURNAL OF RADIOLOGY
 CLINICAL PROCEEDINGS OF THE CHILDREN'S HOSPITAL, WASHINGTON, D. C.
 JOURNAL OF INVESTIGATIVE DERMATOLOGY
 JOURNAL OF THE AMERICAN GERIATRICS SOCIETY
 ORAL SURGERY, ORAL MEDICINE, AND ORAL PATHOLOGY
 THORAX

* Indicates gifts.

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, November 27–December 24, 1953

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARA- LYTIC	POLIOMYELITIS, NON PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County.....	65	—	3	1	13	—	33	4	1	—	12	—	—	3	10	1	4	r-3	4
Anne Arundel.....	2	—	—	3	—	1	3	1	—	—	—	—	—	25	8	—	2	—	5
Howard.....	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—	—	—	—
Harford.....	2	—	—	12	—	1	15	—	—	—	17	—	—	5	5	—	—	—	1
Carroll.....	2	—	—	2	1	—	—	1	—	—	1	—	—	—	4	—	1	—	4
Frederick.....	4	—	2	1	—	—	1	1	—	—	9	—	—	6	2	—	3	—	—
Washington.....	—	—	—	4	—	—	—	2	2	—	—	—	—	—	—	—	2	—	1
Allegany.....	1	—	—	9	—	—	1	1	—	—	2	—	—	—	2	—	—	—	3
Garrett.....	—	—	—	2	—	—	—	1	—	—	3	—	—	—	—	—	—	—	—
Montgomery.....	9	—	1	—	2	—	28	—	—	—	7	—	1	—	9	—	—	tu-2	—
Prince George's.....	6	—	—	2	—	—	5	1	—	—	11	—	—	2	9	—	6	—	4
Calvert.....	—	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—
Charles.....	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Saint Mary's.....	—	—	—	2	—	—	1	—	—	—	1	—	—	—	—	—	4	—	2
Cecil.....	—	—	—	5	—	—	—	1	—	—	—	—	—	—	2	—	3	—	—
Kent.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—
Queen Anne's.....	—	—	—	—	—	—	6	1	—	—	—	—	—	—	—	—	—	—	—
Caroline.....	2	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	2	t-1	—
Talbot.....	1	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	e-1	—
Dorchester.....	—	1	—	—	1	—	1	—	—	—	—	—	—	—	1	—	10	tu-1	2
Wicomico.....	1	—	—	—	49	—	—	1	—	—	—	1	—	—	1	—	5	—	1
Worcester.....	1	—	1	3	5	—	3	—	—	—	—	—	—	—	1	1	—	—	1
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Total Counties.....	97	1	7	48	71	2	97	15	3	0	63	1	1	45	58	2	46	—	29
Baltimore City.....	192	0	5	8	194	2	176	1	0	0	38	0	0	57	108	5	424	t-1	24
State																			
Nov. 27–Dec. 24, 1953..	289	1	12	56	265	4	273	16	3	0	101	1	1	102	166	7	470	—	53
Same period 1952.....	278	12	1	27	24	1	65	5	0	0	85	3	0	31	173	16	595	—	51
5-year median.....	237	6	7	—	80	3	69	8	—	0	83	4	2	85	184	69	526	—	50
Cumulative totals																			
State																			
Year 1953 to date.....	3188	12	1462	503	1973	77	2762	304*	216	25	2368	32	13	477	2259	150	7642	—	689
Same period 1952.....	3192	25	850	249	9151	80	1063	199	161	28	1033	23	15	225	2599	192	7440	—	630
5-year median.....	3437	74	542	—	4130	65	1723	—	226	56	1065	38	41	827	2672	852	7473	—	600

e = infectious encephalitis.

r = positive reports of rabies in animals.

t = tetanus.

tu = tularemia.

* = 13 cases of paralytic poliomyelitis have been removed from the records, not poliomyelitis, these cases were from Chestnut Lodge, Montgomery County, July 1953.



Blue Cross - Blue Shield



BLUE SHIELD HAS COME OF AGE

J. M. T. FINNEY, III*

The facts are clear. Better than words, they measure—for you and for us—the growth of Blue Shield. More than 1700 Maryland doctors, participants in Blue Shield, provide services for some 220,000 subscribers. And in 1953, the third year for the Maryland Medical Service, payments to doctors amounted to more than 1¼ million dollars—for their services to 25,000 members.

The doctors themselves recognized the need for pre-payment: a program to help defray the cost of medical and surgical care. They wanted to do it in the "American Way." They wanted, primarily, to preserve the patient-doctor relationship, and, just as important, the patient's right to choose his own doctor. What they did not want was a political or governmental control which would accompany any compulsory system. The program had to be voluntary.

Their search for a voluntary system of prepaid medical and surgical care brought results in 1939 when the first non-profit plans under sponsorship of state medical societies and the A.M.A. were begun. Careful studies, conceived and directed by the Medical and Chirurgical Faculty with the help of local business men and specialists in insurance, produced a program—for Maryland—which, in 1951, united with other plans known, collectively, as Blue Shield. For this effort, you—Maryland's doctors—deserve a vote of thanks.

Your sponsorship and your participation testify to your faith in Blue Shield. Its growth demonstrates the public's desire for such a program and, significantly a faith in the doctors who sponsor it. But for Blue Shield to maintain its growth it must have the continued support of all physicians.

Its popularity depends very largely upon your endorsement.

For stability, it must rely upon your protection.

Its worth depends upon your execution of its principles.

The vast majority of Maryland's physicians recognize these facts. An analysis of experience in 1953 reveals that over 90% of the Blue Shield members hospitalized were treated by participating physicians. In accordance with their agreement with Blue Shield, these physicians accepted the Blue Shield benefit as payment in full for care to those members whose incomes were below the specified limits. It is significant to note that they also accepted the Blue Shield benefit as payment in full for more than half (50.3%) of those members whose incomes exceeded the limits. Altogether, the Blue Shield benefits were accepted as full payment in 70.3% of all cases reported by participating doctors; the payments made by Blue Shield amounted to 76.2% of total charges for all cases.

This support—your support—is the measure of Blue Shield popularity. No commercial insurance program can match it. It is this kind of support that makes Blue Shield an ever increasing part of every doctor's practice. And Blue Shield, in return for this support, helps the medical profession.

Blue Shield, nationally, has already played a major part in the political demise of compulsory health insurance. It has created a public awareness of the efforts of the profession to put its own house in order and by these efforts, to place the best in medical and surgical care within reach of all Americans. As its growing membership increases the doctor's percentage of collection, it likewise reduces the problem of dunning patients for unpaid bills. Blue Shield payments are prompt. They insure an income for the doctor, even in a period of recession. And unlike any commercial program, Blue Shield is controlled by the doctors themselves—in premise and in execution.

* Assistant to the Director, Maryland Medical Service, Inc.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. CHARLES H. WILLIAMS, *Auxiliary Editor*



DR. MAURICE C. PINCOFFS, President of the Medical and Chirurgical Faculty of the State of Maryland chats with MRS. JOHN G. BALL, President, and with MRS. A. E. GOLDSTEIN, President-elect, of the Woman's Auxiliary at the Semiannual Meeting held at the National Institutes of Health in Bethesda, Maryland

DOCTOR'S WIFE HAS HER OWN TEN COMMANDMENTS

(Taken from Illinois Medical Journal,
August, 1940.)

She must not know the meaning of the word
"jealous."
She must never gossip.
She must run a cafeteria, serving meals at all hours
for her husband.
She must be—like Caesar's wife—above reproach.
She must have self-reliance and self-control.

She must be able to think quickly and sanely in
emergencies.

She must be a diplomat, see all, hear all, say a lot,
yet say nothing.

She must learn to bear stoically and without com-
plaint, disappointments in her personal plans.

She must be a good mother and father, because
doctors are often too busy to discipline their own
children.

She must be a good "doctor" because doctors never
take time to doctor themselves.—Author Un-
known, Wichita Medical Bulletin.

VOLUNTARY HEALTH INSURANCE SHOWS GAINS*

In all parts of the country, the American people voluntarily increased their protection against the unexpected costs of hospital, surgical and medical care to new heights in 1952—reports the Health Insurance Council in its current annual survey of accident and health coverage in the United States. The AMA's Council on Medical Service is distributing copies of the report to medical schools, teaching hospitals, and state and county medical societies.

Organizations contributing data to the Insurance Council's report include insurance companies, Blue Cross, Blue Shield and various other independent plans sponsored by business and industry, employee benefit associations and private group clinics.

Statistical highlights of the report: Nearly 92 million covered against *hospital expense*, an increase of more than 5½ million over 1951; more than 73 million protected against *surgical expense*, an increase of more than 7½ million; nearly 36 million carried *medical expense* coverage, an increase of 8 million; more than 38 million protected by *disability insurance*, a new high. In addition, nearly 700,000 persons had *catastrophic coverage*—the newest form of voluntary health protection designed to help meet the catastrophic costs of very serious illness.

Additional copies of the report are available on request from the Council on Medical Service.

CONFERENCE OF FEDERAL CIVIL DEFENSE ADMINISTRATION

NATIONAL WOMEN'S ADVISORY COMMITTEE

F.C.D.A., 1930 Columbia Road, N.W., Washington
25, D. C.

October 6th and 7th, 1953

Conference Roundtable on Emergency Care Services

Chairman: Dr. Mary H. S. Hayes,

Secretary: Mrs. George H. Yeager, Woman's Auxiliary to The American Medical Association.

Background: Dr. Robert H. Flinn explained to the roundtable group that medical plans for Civil

Defense are based upon an expected five million casualties, in the event of atomic attack, two-thirds of which, or three million, three hundred thousand, will require hospital care.

Since the downtown hospitals of key cities will be knocked out, it is hoped that doctors and nurses can be flown in from surrounding territory. It would not be possible, though, to fly in the quantities of auxiliary nursing aides needed to care for the sick. The temporary two hundred bed hospitals set up around the city would each require fifteen doctors, probably including dentists and veterinarians, thirty-five professional nurses, one hundred auxiliary nurses, and seventy-five untrained auxiliary nurses.

Since professional medical personnel will have time only to direct the temporary two hundred bed hospitals, women's organizations are urged to see that their members, in both self-interest and public preparedness, take the following courses:

1. The Red Cross Home Nursing Course—which needs volunteers, both as students and trainers' (teachers). Appropriate to organizations interested in health field.
2. The Red Cross First Aid Course. Appropriate to organizations working in health field.
3. The Emergency Feeding or Canteen Service, Red Cross or Salvation Army, etc. This seems especially appropriate for members of groups interested in home economics.

Volunteer support was asked also for:

1. The Blood Plasma Program of the Red Cross, or of Private Blood Banks. (Expanders, while helpful, will not replace the need for plasma and whole blood).
2. The Block Warden Program of Civil Defense. The Warden as block chairman of neighborhood group must deal with welfare, fire, rescue, policing, care of children and invalids, communal feeding, sanitation, and be a sort of "Paul Revere."
3. The encouragement by women of participation by their husbands and families in the Civil Defense Program (with peacetime as well as war benefits).
4. The use of the Home Defense Action Plan of Civil Defense. A kit on Home Defense Action covers welfare, supply, emergency mass feeding, action outline, TV spot explanations, home shelters, and warden handbooks.

* Reprinted from News Notes—A.M.A., Vol. 2, No. 10.

CIVIL DEFENSE

REPORT ON FEDERAL CIVIL DEFENSE
ADMINISTRATION'S
NATIONAL WOMEN'S ADVISORY
COMMITTEE

October 6th and 7th, 1953—Olney, Maryland

To: Mrs. Leo J. Schaefer, President, Woman's
Auxiliary to the American Medical Association.

By: Mrs. George H. Yeager, serving as Alternate.

Report

Now that Russia has the atomic bomb and the TU4 type bomber to transport it, the threat of the use of the bomb by the United States is no longer a key to Civil Defense, nor is the question of Russia's possession of the hydrogen bomb important. Each American city must now plan that Russia has sufficient power to wipe out with one bomb, all its hospitals, with its doctors and nurses, its industry with its skilled labor, and its transportation system. The loss of industry in major cities will affect the interdependent manufacture in smaller communities. The key strength of our cities must be the support of the surrounding territory. Planes attacking American cities by flying across Alaska and Canada will have enough gasoline, after hitting their targets, to fly on to South America for the internment of the pilots. The cities so attacked would be "killed"—gone at least for a year or years.

Early warning of an imminent attack is vital to our cities. There is now no warning possible, especially to peripheral or border cities. We must get two hours warning to the cities on our peripheries. Then we can thin out heavily populated areas. Like a fire drill, a temporary withdrawal would reduce casualties by perhaps 80 per cent. We know that the use of ten atomic weapons could put out our entire railroad system. Therefore, we must plan to rebuild them if we are to continue to wage a war.

It is vital that we have a population educated in Civil Defense, or self preservation. Since the great majority of Civil Defense workers must be women, women's organizations must start practical programs of basic Civil Defense training for their members—not lectures, but to learn by doing. We must train people in home nursing as nurses' aides, as wardens,

and in rescue work. Wardens will train new wardens; nurses' aides, new aides; etc. Instead of a talk, get help from the police or the fire department and demonstrate at your meetings the use of rope and an ordinary step-ladder in rescue work. Anybody can do this, and you can be useful to the depleted rescue team if it arrives, during a bombing, or help your own out of the rubble. Film strips sent to National Women's Organizations will guide them as to what fire and police departments can teach them in self help.

Since pamphlets are no good unless applied, it is important to have our schools and colleges include Civil Defense as part of their regular curriculum. Civil Defense is now part of American life and each citizen's responsibility. With small children it is important to practice dead-pan, unemotional duck-and-cover drill, to have them wear identification bracelets, and to show them Civil Defense films, and to teach responsibility with faith in the future and life itself. Morale is always as important as shelter and we must fight neutralism, defeatism, despair, and the fact that people accept the bomb intellectually, but turn away, emotionally. Credit courses for Civil Defense in colleges and the mobilization of teaching facilities by twelve state governors are trends in the right direction.

Women's organizations should put on a practical action course that is simple, but will bring big results. Let us convince our members that after taking a few hours' training they can stand by, prepared rather than helpless in an emergency, whether it be peacetime or war. The Auxiliary to The American Legion has already sent leaders to the Olney, Maryland, Civil Defense Training Center, for a full week's course in Civil Defense. One great job that women will have will be to spike rumors. The enemy will use psychological warfare to twist our own warning system, our radio announcements, and may drop leaflets purporting to be from our own Government. The people who survive must be educated to the possibilities of psychological warfare.

We have in existence today an intricate national warning system and in our warehouses there are sixty millions of dollars worth of medical supplies. Our greatest and crucial defense against Russia, however, must be spiritual. This country was founded on Christian religious principles, including

the Ten Commandments, and Jesus gave as the most important of these, the first—"Thou shalt love the Lord thy God with all thy heart, and with all thy soul, and with all thy mind, and thy neighbor as thyself." Our spiritual strength will rest on this foundation.

Any comprehension of the magnitude and scope of the problem of atomic attack brings us, indeed, to our knees before God. We must have faith and show it by actually training ourselves for the days when each home may be a hospital—as home

nurses, nurses' aides, block wardens (at least in the daytime hours), as emergency cooks who can use salvage equipment, as trainees in sanitation problems, in registration and information services, and by convincing people that home and mass shelters are necessary.

The "know-how" of these things is provided in a kit called the *Home Defense Action Program*, and when people understand from a candid government what confronts them, they will want Home Defense Action.

Ancillary News



PHARMACY SECTION



NARCOTICS

L. M. KANTNER, PHAR.D.*

This article is prompted because of a telephone message recently received from an irate pharmacist. His anger was caused by what is substantially related here (profanity deleted).

"A physician just called me to take a prescription by phone, which among other ingredients contained morphine sulfate. When I advised the physician accepting verbal prescriptions for narcotics was in violation of the Narcotic Act he replied, 'I will call another drug store,' and hung up the telephone receiver without giving his name. I want to know what I can do about such a matter." Naturally the only answer that could be given there was nothing that could be done except for him to control his fit of anger.

As this is a complaint that is frequently made by pharmacists, it does not seem amiss from time to time to call attention to certain regulations pertaining to the prescribing and dispensing of narcotics, and the responsibilities that both the prescriber and dispenser must assume in dealing with these drugs.

Under Chapter 8, Art. 172, Narcotic Regulations, telephone orders are very definitely dealt with as follows:—The furnishing of narcotics pursuant to telephone advice of practitioners is prohibited, whether prescriptions covering such orders are subsequently received or not, except that in an emergency a druggist may deliver narcotics through his employee or responsible agent pursuant to a telephone order, *provided* the employee or agent is supplied with a properly prepared prescription before delivery is made.

Prescriptions for narcotics cannot be refilled under any circumstances, a new prescription must be fur-

nished when narcotic medication is to be continued. In conversation with a physician a short time ago it developed he had confused the Harrison Narcotic Act with the Durham-Humphrey Act. He was under the impression the Durham-Humphrey Act applied to all types of drugs including narcotics, which of course it does not—the provisions of the Durham-Humphrey Act come under the supervision of the Food and Drug Administration, Department of Health, Education & Welfare, while the Narcotic Act comes under the Bureau of Narcotics, Treasury Department. Virtually all physicians are meticulous when it comes to administering and prescribing narcotics, because they fully appreciate the danger and ease that a patient can develop addiction.

The error they sometimes make in prescribing narcotics is largely due to thoughtlessness. For instance prescriptions for narcotics cannot legally be written with pencil—they must be written with ink or indelible pencil or typewritten and in the latter case they must be signed with ink or indelible pencil—by the prescriber, a secretary cannot sign a narcotic prescription. If a pharmacist accepts a narcotic prescription by phone and dispenses it, naturally it is he who is the violator. No responsible physician would deliberately provoke a condition that would cause another to become involved in a law violation particularly one involving narcotics. However, this is exactly what happens when a physician requests a pharmacist to accept a prescription for narcotics by phone and it is dispensed, notwithstanding a signed prescription is promised to be supplied later.

Certainly a pharmacist can refuse to accept a narcotic prescription that a physician wishes him to take by telephone as in the case of the pharmacist who provoked this article. However if a pharmacist refuses to comply with such a request an unpleasant relationship is likely to result, which all

* Secretary, Maryland Board of Pharmacy.

well thinking pharmacists endeavor to prevent. Again it is recommended that physicians include on prescriptions (except those for narcotics) to refill a definite number of times *or* not to refill (N. R.)

This will save physicians the annoyance of pharmacists calling for authorization to refill a prescription that contains a drug that cannot be dispensed except on a prescription.

15-MAN HOOVER MEDICAL TASK FORCE COMPLETED: HAS 13 M.D.'S

The AMA Washington Letter, No. 46

The announcement of 12 more appointments completes the membership of the Hoover Commission task force on medical services. Earlier the commission named Mr. Chauncey McCormick, Chicago businessman, as chairman, and Dr. Edwin I. Crosby, also of Chicago, as research director. The third appointment announced earlier was that of Dr. Walter Martin, president-elect of the American Medical Association.

The following have accepted appointment to the remaining posts: *Dr. Francis J. Braceland*, dean, Loyola (Chicago) University School of Medicine, naval reserve captain, member Armed Forces Medical Advisory Committee; *Dr. Edward Delos Churchill*, chief of general surgical service, Massachusetts General Hospital, medical veteran both World Wars, member medical task force of first Hoover Commission; *Dr. Michael DeBakey*, professor of surgery and chairman of department of surgery, Baylor University College of Medicine, Army medical officer in World War II, member medical task force of first Hoover Commission; *Dr. Evarts A. Graham*, surgeon-in-chief, Barnes Hospital and St. Louis Children's Hospital, medical veteran of World War I; *Dr. Alan Gregg*, vice president of Rockefeller Foundation, medical veteran of World War I, member Health Resources Advisory Committee, ODM; *Dr. Paul R. Hawley*, retired regular Army major general, director American College of Surgeons, former chief medical director, Veterans Administration; *Dr. Theodore George Klumpp*, president, Winthrop-Stearns, Inc., N. Y., and Winthrop Products, Inc., N. J.; *Dr. Hugh Rodman Leavall*, professor of public health practice, Harvard School of Public Health, member medical task force of first Hoover Commission; *Dr. Basil C. MacLean*, director, Strong Memorial Hospital and professor of hospital administration at University of Rochester, Army medical officer in World War II, consultant to medical task force of first Hoover Commission; *Dr. James Roscoe Miller*, president of Northwestern University, Army and Navy service in World War II; *Dr. Milton C. Winternitz*, chairman, division of medical sciences of National Research Council, Army medical officer in World War I; *Dr. Otto W. Brandhorst*, dean of Washington University (St. Louis) School of Dentistry.

Book Reviews*

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them.

Sex After Forty. S. A. Lewin, M.D., and John Gilmore, Ph.D. First printing, April, 1952, Medical Research Press, New York. Distributed by Grosset and Dunlap. Introduction, Rev. Dr. Russell L. Dicks, Duke University. 188 pages, plus glossary and index. Illustrated. \$3.50.

This book is widely received. It is already in its second printing. It is a very dignified and authoritative exposition of the subject. It has in it highly instructive and educational material. The chapter on endocrine glands is especially instructive and clear. In it is a compilation of authoritative views of the clergies on debatable subjects, all set down in simple and clear language. This book should have wide circulation, especially among the lay people.

W. H. T.

Textbook of Gynecology. Emil Novak, A.B., M.D., D.Sc. (Hon.), F.A.C.S., F.R.C.O.G. (Hon.), Assistant Professor Emeritus of Gynecology, The Johns Hopkins Medical School; Gynecologist-in-chief, Bon Secours and St. Agnes Hospitals, Baltimore; and Past President, American Gynecological Society; and Edmund R. Novak, A.B., M.D., F.A.C.S., Instructor in Gynecology, The Johns Hopkins Medical School; Gynecologist, Johns Hopkins, Bon Secours, St. Agnes and Union Memorial Hospitals, Baltimore. Fourth edition, 1952, The Williams and Wilkins Company, Baltimore. 781 pages plus index. Illustrated. \$9.00.

Dr. Novak states in an earlier preface, "The purpose of this book is to present as much information on gynecology as possible in a simple and practical fashion." He and his son have done this very well in this fourth edition. The material has been brought up to date in many chapters. A very timely and interesting discussion has been given to intraepithelial carcinoma. Other noted additions are the basal temperature chart in reference to ovulation, and Dr. Everett's revision of the section on female urology which includes the addition of the judicious use of antibiotics in urinary tract infections.

I highly recommend this text to medical students, general practitioners, and the gynecologists and obstetricians.

T. K.

* The reviews here published have been prepared by competent authorities and do not represent the opinions of any official bodies unless specifically stated.

The Literature on Streptomycin. Selman A. Waksman. Second edition, 1952, Rutgers University Press, New Brunswick, New Jersey. 553 pages. \$5.00.

This book is a non-annotated bibliography on streptomycin. Five thousand, five hundred and fifty (5,550) references are listed without regard to any sequential format. However, author and subject indices are provided. This book should prove useful to the libraries of antibiotic research laboratories and to large medical institutions as an ancillary reference aid only.

M. J. S.

The Low Fat Diet Cook Book. Dorothy Myers Hildreth, Dietitian, and Eugene A. Hildreth, M.D. Introduction by Francis C. Wood, M.D. Copyright 1952, Medical Research Press, New York. Distributed by Grosset and Dunlap. 131 pages plus index. \$2.95.

"The Low Fat Diet Cook Book" (Hildreth and Hildreth) presents basic facts upon which diets can be prepared to meet the requirements of individual cases. Menus can be planned if one follows diligently the fat restrictions noted, servings allowed and substitutions suggested. Mrs. Hildreth's menus for an entire week offer attractive and palatable meals, easily prepared from her recipes.

The supplementary recipes include many highly seasoned ones. Natural flavors are hidden instead of being enjoyed for themselves. These recipes, if followed too literally week after week, might cause metabolic disorders or intensify the circulatory ailments of advancing age which the physician is striving to lessen. Many of them read like good eating for the family and, occasionally, for the patient.

Special diets require close cooperation between the physician or dietitian, the one handling the diet and the patient. The effectiveness of any diet is measured by the achievements of the person administering same and the ability of the patient's body to use the foods offered. Naturally best results are obtained when the diet is administered by one having some general knowledge of foods and nutrition. However, simple directions can be followed and, if one is willing, much knowledge can be gained.

This book, and all other diet books, should supply basic information on the proper selection of foods, steps in preparation of same and modern methods of cooking.

Simple explanations of digestion, absorption and assimilations should be given. Charts furnishing the average chemical compositions, vitamin and mineral contents of foods, especially fruits and vegetables, their digestibility and caloric values should be included.

Given some instruction and having an eagerness to learn and achieve, one can then plan menus using those foods which supply the greatest curative, nutritional and protective elements. Both the patient and the family can be fed well and wisely.

R. A. R.

Monograph on Chlorophyll in Medicine. Published by Rystan Company Inc., Mount Vernon, New York. Copyright 1952. 53 pages. Illustrated.

This booklet may prove interesting, and may be secured without cost by writing to the Rystan Company, Inc., Mount Vernon, New York. Chloresium, which is featured in this booklet, is an A.M.A. Council accepted product.

A. J. J.

NO DOCTOR DRAFT NEEDED AFTER 1955, U. S. OFFICIALS AGREE

The AMA Washington Letter, No. 46

Present Defense Department planning envisions no extension of the doctor draft beyond July 1, 1955, but instead it calls for a program of "fence mending" and "belt tightening," federal officials concerned with the law stated at the annual meeting of the Association of Military Surgeons. This position was outlined at the same time that *Dr. Edward J. McCormick*, president of the American Medical Association, told the surgeons: "It is our belief that this is a most propitious time for devising a program which will clearly eliminate any need for this legislation well in advance of July 1, 1955."

Dr. Melvin A. Casberg, Assistant Secretary of Defense (Health and Medical), said steps taken or planned to stimulate regular medical officer procurement include study of a law to provide medical scholarships to students commissioned in the armed forces following graduation. He said, however, that this will create a problem: "All Indians and no chiefs." It is the duty of civilian organizations, he said, to aid the military in procuring more experienced doctors for teaching and training posts in the services.

Dr. Howard A. Rusk, chairman of the Health Resources Advisory Committee, recommended a further reduction in the physician-troop ratio, from a projected 3.2 to 2.9, as one form of belt tightening. If the size of the armed forces doesn't increase, he believes it should be possible to meet requirements after mid-1955 from each year's graduating classes. In the meantime, however, drafting of doctors will resume late next summer or early fall, he said, with possibility that as many as 1,250 Priority III doctors in their early 30s will have to be called during the life of the act.

Dr. McCormick also made these points: (1) the problem of medical care for military dependents should be turned over for study to the Hoover Commission on government reorganization, with final determinations by Congress, (2) meanwhile there should be improved utilization of military medical personnel and curtailment in non-professional duties, (3) in the event a universal military training program is voted, then pre-professional and professional education for qualified students should be continued.

Letter to the Editor

October 30, 1953

Dr. George H. Yeager, Editor*
Maryland Medical Journal
1211 Cathedral St.
Baltimore, Md.

Dear Dr. Yeager:

Just to set the record straight, some comments seem necessary regarding a report on the function of the "County Medical Care Program" written by Dr. R. H. Riley, Director of the State Health Department. This article describes the action taken by the Health Department against seven physicians in the counties as "the functioning of the Medical Care Program" and totally ignores the wonderful work of almost one thousand hard-working conscientious physicians. Many of these doctors who participate in the county Medical Care Program do not make any charge at all to the State for their services to the poor and all of them have expressed their willingness to continue to treat indigent patients irrespective of the fee. A description of the Baltimore County Medical Care Program has been published in the Directory of same and is as follows:

"For a number of years, all over the United States, it has been realized that, in spite of the high quality of medical care available to our citizens, defects exist in the system. In the public mind the two most glaring defects seem to be that a few people do not have the money to pay for this medical care, and that a larger number suffer great financial distress in cases where illness is long drawn out, especially where the breadwinner of the family is affected.

Until very recently it was taken for granted that these problems were to be met by physicians rendering free service to the indigent, and by private charities taking care of the other financial needs of these unfortunates. However, many people are now beginning to feel that it is the responsibility of a government to take care of all its citizens, and that

* Article read before the Baltimore County Medical Association at the meeting just prior to November 6, 1953, and it was voted unanimously to have it published in the Maryland State Medical Journal.

it is therefore up to our government to see that everyone gets adequate medical care, and is protected from financial hardship during illness.

Regardless of the correctness of this political philosophy, it has become obvious to our national leaders that public opinion demands that something be done. Under this pressure various schemes have been proposed, schemes which have ranged all the way from attempts to have the national government take complete responsibility for all medical care ("socialized medicine"), to the development of voluntary insurance systems such as the Blue Cross.

In Maryland a method has been developed whereby the state accepts responsibility for medical care of its most needy citizens, but without falling into the trap of governmental interference with medical practice. Under it the state supplies the funds, each county administers the service according to the peculiar needs of the locality, and each patient has complete freedom in selecting his own physician.

For the benefit of those interested, a summary of the details of this system, as it currently works in Baltimore County follows:

The County Medical Care Program was founded in 1945, on the basis of a request from the Medical and Chirurgical Faculty made in 1939. The interim period was taken up by a detailed study of the medical needs and facilities for low-income families in the counties of Maryland. The recommendations of the study group were unanimously approved by the Faculty in 1944 and became the law of the State in 1945.

The program is founded on the following basic principles, some explicit and others implicit in the law and the regulations:

(1) The program is State-financed, with no Federal aid or intervention.

(2) It is based on the prevailing method of medical practice in the counties, namely, a fee-for-service system in which the general practitioner is the key figure.

(3) It is administered by the State Department of Health.

(4) It is designed to take care of the medical needs (exclusive of hospitalization which is under a different program) of those on relief and a group of so-called medically indigent, who are normally self-supporting but cannot afford the cost of illness.

(5) It is dedicated to the maximum possible amount of professional freedom and the minimum amount of regulations consistent with efficient, economical administration.

(6) It is dedicated to the free choice of physician (and other professional personnel) by the patient, as well as to the professional participant's right to accept or refuse patients as he desires.

The program provides the following services:

(1) Physician's Service in the home, office, and nursing home. Delivery in the home or hospital. Consultant services may be made available.

(2) Drugs as prescribed or dispensed by the physician, with very few limitations in the way of experimental drugs.

(3) Dental Services, including fillings, extractions, X-ray, fluoride therapy, and dentures on a limited basis.

(4) Special Diagnostic Services, beyond the scope of the physician's office, in hospital, outpatient departments.

Who is Eligible?

(1) All recipients of public assistance are automatically eligible.

(2) Any person who believes himself to be unable to pay for medical care may apply to the Health Department in the county of his residence. Eligibility is determined on the basis of objective standards of income and resources, and in exceptional cases, on the health officer's judgment concerning medical and social needs. Eligible patients are identified by special cards issued by the Health Department.

How may a Physician Participate?

Any licensed physician may participate automatically by submitting bills for any eligible patient. One bill is submitted for each patient seen during a given month. Payment is promptly made by the end of the month, following the month during which services were rendered. Bill forms and detailed instructions may be obtained from the County Health Department in the county of the physician's residence."

This program has proven eminently successful to both doctor and patient and has the cooperation of 95% of the physicians. This is direct contrast to the panel system in Baltimore City where physician participation is small and patient does not have free choice of doctor or hospital.

Leaders in medicine throughout our country have called Maryland's County Medical Care Program the answer to threats of socialized medicine in the care of the indigent patient.

Yours very truly,
Charles H. Williams, M.D.,
Chairman
Board of Governors
Baltimore County Medical
Association, Inc.

HEALTH OFFICERS OPPOSE CUTS IN FEDERAL GRANTS

The AMA Washington Letter, No. 46

The Association of State and Territorial Health Officers opposes further cuts in federal grants-in-aid for health programs pending action of the Commission on Intergovernmental Relations (Manion Commission), which is studying the whole field of federal-state relationships. The association also urges that once Congress implements any commission proposals it give the states time to make budgetary adjustments, because some legislatures meet only every two years. The association took these stands at its annual meeting in Washington with federal health officials. It also (a) recommended that more funds be spent for civil defense at both federal and state levels, (b) urged passage of legislation transferring Indian hospitals to PHS, with the consent of the Indians, (c) recommended that AMA and other groups cooperate in a campaign for routine chest examinations of all hospital admissions and periodic x-rays of staffs, (d) recommended that necessary steps be taken to assure that the 1954 supply of gamma globulin will be adequate for reasonable foreseeable needs.

COMING MEETINGS

SYMPOSIUM ON THE MEDICAL AND LEGAL ASPECTS OF MALPRACTICE

Osler Hall, 1211 Cathedral Street

Thursday, February 4, 1954, 8:00 p.m.

Moderator—The Honorable Lansdale G. Sasscer

Participants to be announced later.

These programs are arranged under the auspices of the Subcommittee on Symposia Management of the Joint Medicolegal Committee of the Bar Associations and the Medical and Chirurgical Faculty.

This is a vital subject and all the members of the Medical and Chirurgical Faculty are urged to arrange their schedules so that they can be present.

POSTGRADUATE COURSES

Presented by the Baltimore City Medical Society, its Sections, and the Maryland Academy of General Practice.

HEMATOLOGY

New Class Room—The Johns Hopkins Hospital

Wednesday Evenings, 7:30 to 9:30 p.m.

February 3, 1954 Diagnosis and Treatment of Anaemias.	C. Lockard Conley, M.D.
February 10, 1954 Leukemias and Lymphomas.	Milton S. Sacks, M.D., and Staff
February 17, 1954 Hemorrhagic Disorders.	Dudley P. Jackson, M.D.
February 24, 1954 Blood Groups, Immunology, including Erythroblastosis and Transfusion Problems	Milton S. Sacks, M.D., and Staff

WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

Mrs. Thomas C. Webster, *President*

Mrs. Conrad Acton, *Secretary*

Mrs. Whitmer B. Firor, *Treasurer*

Wednesday, February 3, 1954, 11:00 a.m., Osler Hall

Dr. Murray C. Brown, Chief of Clinical and Professional Education at the Clinical Center of the National Institutes of Health, Bethesda, Maryland, will speak on the program and facilities of the National Institutes of Health. (Illustrated.)

Collation

NEUROPSYCHIATRIC SECTION

Leonard J. Gallant, M.D., *Secretary*
Thursday, February 11, 1954, 8:30 p.m.
Faculty Building, 1211 Cathedral Street

Dynamic Considerations in the Treatment of Schizophrenia. Lewis B. Hill, M.D., Psychiatrist-in-Chief, Sheppard and Enoch Pratt Hospital.

Discussants:

John C. Whitehorn, M.D., Professor of Psychiatry, The Johns Hopkins University School of Medicine.

Sarah S. Tower, M.D., Assistant Professor of Psychiatry, The Johns Hopkins University School of Medicine.

RADIOLOGICAL SECTION

David N. Gould, M.D., *Chairman*

H. Leonard Warres, M.D., *Secretary*

**JOINT MEETING WITH THE OBSTETRICAL AND GYNECOLOGICAL
 SOCIETY OF MARYLAND**

Tuesday, February 16, 1954, Sheraton Belvedere Hotel

Film-reading Session, 5:30 p.m.

Cocktails 6:30 p.m. Dinner 7:30 p.m.

Scientific Session, 8:30 p.m.

Radiation Therapy of Carcinoma of the Cervix. Isadore Lampe, M.D., Professor Roentgenology, University of Michigan, Ann Arbor, Michigan.

ALL WHO ARE INTERESTED ARE INVITED TO ATTEND THE FILM READING
 SESSION AND THE FORMAL LECTURE.

ANESTHESIA STUDY COMMITTEE

Wednesday, February 17, 1954, 8:30 p.m.

Faculty Building, 1211 Cathedral Street

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and
 Chirurgical Faculty.

Richard W. TeLinde, M.D., *Chairman*

Beverly C. Compton, M.D., *Secretary*

Thursday, February 18, 1954, 5:00 to 6:00 p.m.

1211 Cathedral Street, Lower Floor

BALTIMORE CITY MEDICAL SOCIETY

Osler Hall, 1211 Cathedral Street

Friday, February 19, 1954, 8:30 p.m.

8:45 p.m.

Hypothermia. Kenneth K. Keown, M.D., Associate Professor of Anesthesiology, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania. (Illustrated.) (By invitation.)

9:30 p.m.

Hypotensive Anesthesia. Hrant H. Stone, M.D., Director, Department of Anesthesiology, Graduate Hospital, University of Pennsylvania; Assistant Professor of Anesthesiology, Graduate School of Medicine, University of Pennsylvania; Associate Professor of Anesthesiology, Woman's Medical College of Pennsylvania, Philadelphia, Pennsylvania. (By invitation.)

10:15 p.m.

Question Period

MATERNAL MORTALITY COMMITTEE

Thursday, February 25, 1954, 4:00 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the Baltimore City Health Department.

THE SOUTHEASTERN SURGICAL CONGRESS BIRMINGHAM ASSEMBLY

Twenty-Second Annual Meeting

MARCH 8, 9, 10, 11, 1954

SPEAKERS

Jack Greenfield, M.D., Memphis, Tenn.

A Diagnostic Survey for Extragastrintestinal Left Upper Quadrant Lesions

William G. Hamm, M.D., Atlanta, Ga.

Elephantiasis of the Lower Extremities

John K. Webb, M.D., Greenville, S. C.

Adrenalectomy in Recurrent Breast Carcinoma

Waltman Walters, M.D., (Guest), Rochester, Minn.

Obstructive Jaundice, Its Diagnosis and Treatment

Michael E. De Bakey, M.D., (Guest), Houston, Texas

Surgical Considerations of Aortic Aneurysms

Kenneth W. Warren, M.D., (Guest), Boston, Mass.

Current Management of Benign and Malignant Pancreatic Tumors

Francis A. Marzoni, M.D., Birmingham, Ala.

The Management of Maxillo-Facial Injuries

George W. Holmes, M.D., Winston Salem, N. C.

The Management of Some Problem Fractures in Children

Leslie V. Rush, M.D., Meridian, Miss.

Three Point Pressure in Fractures Near Joints

M. M. Zinninger, M.D., (Guest), Cincinnati, Ohio

Spread of Cancer of the Stomach Through the Intramural Lymphatics and its Relation to Gastrectomy

Harris B. Shumacker, Jr., M.D., (Guest), Indianapolis, Ind.

The Surgical Treatment of Chronic Constrictive Pericarditis

Raymond W. McNealy, M.D., (Guest), Chicago, Ill.

Pharyngo-Esophageal Diverticula

MARK THESE DATES ON YOUR
CALENDAR NOW AND PLAN TO ATTEND

The Annual Meeting
of the Medical and Chirurgical Faculty



TUESDAY, APRIL 27, 1954 *and* WEDNESDAY, APRIL 28, 1954

Business Meetings, MONDAY, APRIL 26, 1954

Faculty Ball, MONDAY EVENING, APRIL 26, 1954

MORE LIBERAL TAX DEDUCTIONS PROPOSED FOR MEDICAL CARE COSTS

The AMA Washington Letter, No. 45

When Congress reconvenes in January it may be asked to liberalize federal income tax deductions for medical expenses. This is one of the suggestions expected to be made by the staff of the House Ways and Means Committee, which has been working on tax amendments since last summer.

Under present law adjusted, taxpayers may deduct only that part of medical expenses in excess of 5% of gross income. The committee staff is considering proposing that this be changed to 3%. It is estimated that the government would lose \$150 million in revenue annually if this restriction is eased.

Another modification under discussion would eliminate the maximum limitation on medical expense deductions. Now it is \$1,250 per year for a single person, \$2,500 for one with one dependent, \$3,750 for a married couple with one dependent, and \$5,000 for a married couple with two or more dependents. It is pointed out that so few persons contract medical care bills of such size that the revenue loss to the government would be negligible. The committee staff also contemplates recommending raising the \$600 earnings limitation on dependents who are students. The suggestion is to lift this ceiling in the case of students, so parents can continue to claim them as dependents even if their earnings exceed the \$600.

AMERICAN GERIATRICS SOCIETY NOTICE

The American Geriatrics Society announces that effective with January, 1953, they will publish their own official periodical to be called "THE JOURNAL OF THE AMERICAN GERIATRICS SOCIETY." Dr. Willard Thompson, of Chicago, is President of the Society and will edit the journal. Dr. Malford Thewlis of Wakefield, R. I., is Permanent Secretary. All physicians interested in diseases of the aging are invited to join the society. The new journal will be published for the Society by the Williams & Wilkins Company, of Baltimore, Maryland.

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HISTOCHEMICAL SOCIETY NOTICE

The Histochemical Society announces that effective in January, 1953, they will begin publications of a bi-monthly periodical to be known as the "Journal of Histochemistry and Cytological Chemistry." The journal will be published by The Williams & Wilkins Company of Baltimore, Maryland; it will appear every other month beginning January, and the subscription price will be \$7.50. It will be edited by Dr. R. D. Lillie, of the National Institutes of Health, Bethesda, Maryland.



DOCTOR, TAKE THIS HOME TO YOUR WIFE!

Be a member; participate in our program of health education and of support for American principles, fighting Socialized medicine.

Application for Active or Associate Membership

**in the Woman's Auxiliary
to the Medical and Chirurgical Faculty of the State of Maryland
THROUGH THE
WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY
1211 CATHEDRAL STREET, BALTIMORE 1, MARYLAND**

1. NAME.....
2. ADDRESS.....
3. SPONSORING PHYSICIAN.....
4. CHECK TYPE of MEMBERSHIP {Active ☐
Associate ☐
5. DATE.....

Application must be accompanied by membership fee.

Active Dues\$5.00 (wives of doctors who are members*)

Associate Dues\$3.00 (mothers and sisters of doctors who are members or wives of associate members)

* Members of the Baltimore City Medical Society and the Medical and Chirurgical Faculty.



Maryland

STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 3

February, 1954

NUMBER 723

EDITORIAL

C. R. EDWARDS, M.D.*

Rotation in office is a proper expression of our democratic way of government in all of its forms, and when one's term of office is ended, the recent incumbent usually in complacency rejoins the ranks and is happy to be relieved of many duties. Modesty, therefore, would dictate against the writing of these lines but duty says otherwise.



C. R. EDWARDS

The Medical and Chirurgical Faculty was founded 155 years ago. It was founded by an ardent few who felt the need of an interchange of ideas, also the exchange of the few

* Immediate Past Chairman of the Council.

publications that were available, and for infrequent meetings where professional fellowship might prove beneficial. They, also in the early years, wanted and worked prodigiously to establish a library.

Looking back upon those early days from our vantage point, it all seems very simple. Through the years however, slowly, continuous progress has been noted.

Organization of the Medical and Chirurgical Faculty was made effective under our Constitution by planning for a Council and a House of Delegates recognizing all parts of the State.

In subsequent years simplicity seemed to disappear and a more complex, professional life was upon us. The individual "Family Doctor" slowly merged into one in a great community of doctors and organizations. Health Departments, State, County and City, were now organized to extend the benefits of the practice of medicine, to expand certain health laws, and to be of great benefit to both the practitioner and patient.

Blue Cross and Blue Shield and Hospitalization Insurance of various types came into being, and have proved of great value. But all of these organizations call for physicians' membership on their various Board of Directors, and have placed a burden on the officers of the Medical and Chirurgical Faculty.

It can be readily appreciated that the amount of work required of the Headquarters' office has trebled in the past 5 or 6 years. We as a Faculty have been exceptionally fortunate in having Mr. Walter N. Kirkman as our Director. His long experience as a valuable officer in our State government, and his constant contact with our profession, our hospitals and other welfare organizations, fitted him very particularly for the work he has so effectively done for us. He, as well as all of us have been ably assisted by the devoted personnel always to be found at 1211 Cathedral Street.

While the House of Delegates can usually transact its business at the meetings each year—annual and semi-annual, it has proven necessary for the Council to have meetings about every two months, and there is always so much to be done, that for two years we have held our meetings at 4:30 p.m. usually extending until 9 p.m. with a short recess for dinner.

These facts are recorded simply to emphasize the importance of regarding the operations of the Medical and Chirurgical Society as a big business.

Mr. Kirkman has informed the Council that it will be necessary to find a replacement for him in the not too distant future. This will prove a very difficult task, but we must continue to develop our Faculty and in no way permit it to withdraw from any of its responsibilities.

Our Legislative Committee always alert may, before this issue of the Journal is read, find itself busy at Annapolis fighting legislations prepared by various cults who, though totally unprepared, desire to "practice medicine."

The Medical Practice Act has endured many assaults. So far it still stands supreme. We want it as it is, but if we wish to maintain the freedom of the practice of medicine, we must do it ourselves. All kinds of cults attack us, and there have been attempted incursions by certain misguided government agencies or individuals.

In nine years on the Council, and almost three as its Chairman, the writer has learned that the responsibilities of the Medical and Chirurgical Faculty are so numerous, so complex, so continuous, so demanding and so important, that an efficient staff constantly on duty is required.

The devotion to duty and the attendance of the members of the Council has been marvelous to observe, but we have only begun. We have entirely outgrown our facilities, and there could be no better time than now to revive our expansion program and provide ample room for our Headquarters and Library as well as a new auditorium.

FIFTY YEARS—IN RETROSPECT

THE LAST OF THE MEDICAL TRILOGY

The Heritage of Medicine—1933; The Past, Present and Future—1950; Wither Goest Thou?—1953

J. ALBERT CHATARD, M.D.

INTRODUCTION

1903–1953—What a span of years during which so much has happened. Much has been accomplished, and yet so little learned. By learning, I do not mean knowledge, for that has steadily increased beyond all expected attainment; but rather have we learned our lesson well?—have we profited by the past?—have its results been used properly?—or have they been wasted on the efforts to obtain a goal—not yet reached and not to be reached until we retrace our steps and take up each result, year by year. And, as in a “jig-saw puzzle,” put each separate piece into its proper position.

The arraignment of any resulting reward for our struggle can only be reached by looking back, as through a mirror, on the good or bad things that were there. Have we used the inherited good in the right way?—or have we been choked by the bad things on the roadside?—and not developed along the way that leads to truth and the way of life that means so much to future generations?

THE MARCH OF THE DECADES

With some worry about the benefits resulting, I have been asked to add a few words by way of reminiscence.

As you know, historically the first decade of this century developed and crystallized much of the knowledge and research of the late “ninety’s.” Diseases were better known and their treatment and prevention became greatly improved.

The second decade advanced even further, and a great store of knowledge emanated from what was learned during World War I and immediately after.

The third decade was a period of assimilation

during which the knowledge gained was used to increasing advantage.

The fourth decade witnessed new methods and new knowledge of the care of patients. It made a fitting prelude for the very excellent medical care rendered during World War II.

The last decade may be called the “antibiotic years,” giving us wonderful help in the alleviation of many diseases. The future looks bright for many wonderful achievements. However, such developments have put an added burden on the present race by lengthening the span of life to an expectance of about sixty-eight years. A new important study has now arisen called “Geriatrics.”

THE TRANSITION PERIOD

In this brief outline of fifty years we see how much has been accomplished, and how remarkable has been our past. I have tried to bring out the salient points in our present relation to what went before, and how much we owe to those ancestors of ours who practiced what they preached.

Life was simpler then and competition less keen. As I hold the mirror, I see a disquieting picture of the modern practice of medicine. Possibly I am unusually alarmed, however, I have the impression that modern medicine has become materialistic,—and that results are measured in terms of an interesting case! Where, or where, has gone the feeling and relationship of one human to the other—your patient? Success is measured differently these days!—Will it last? Has a Frankenstein risen among us?

OUR PROGRESS

Medicine, as a vocation, has always been on a plane above most other modes of life and

existence. We owe a lot to the past and must work harder than ever to pass this ideal to the future.

To the young man contemplating the study of medicine—I would like to warn him that he must have above all else a “vocation” and not just enter medicine as a method of living. The country doctor has certainly been the best example of “true love” for his profession. His motivation is a desire to benefit his fellow man. The recompense may be little or nothing financially, but to his glory and that of the profession he is the shining example of what can be done.

THE CRITICAL PERIOD

In years gone by when professional matters went wrong, they were settled in two ways: (1) ignoring the past, and (2) trying to patch up the future, forgetting that such a thing happened, and thereby accepting a loss with dignity. This way seemed old fashioned, but it worked successfully. Coming to more modern times, the sad loss of personal contact and interest and friendly relation to our patients, as our best friends, brought out an era (modern age) in which the doctor lost the old close friendship with his patients and became an intellectual automaton. He knows all about disease and treatment. However, without the faculty of applying it, and without the ability of reassurance and solicitation such knowledge

becomes of little avail. In the early days it was often noted that Mr. So and So said he would rather be sick under Dr. A than get well under the care of Dr. B. A smile and optimism, a reassuring hand shake or pat on the back may prove to be extremely helpful.

Let us hope that the new generation of doctors will acquire, with their greater modern knowledge, a little flavoring of the old methods that did so much to endear the “family physician” to the family, from the youngster to the aged. All hail to the personalities that can adjust themselves to the different ages—it is not easy but can be acquired by trying harder to adjust to the patient’s knowledge, his apprehension and his trustfulness.

OUR REWARD

These words may be altruistic but they come from the heart. Far be it for everyone to be perfect—such a race would become monotonous and would leave little inspiration for progress. Differences of nature, mind and soul make up the world about us.

Our highest goal to reach is the one of “charity to all.” In our thoughts, words, and deeds, we have an opportunity to develop and reveal this side of our nature. The reward is exceedingly great. With it have a degree of humility. This enables one to practice in such a manner as to reap the satisfying joy and pleasure of doing something for others.

HOUSE COMMITTEE MAY RESUME HEARINGS ON INSURANCE

The AMA Washington Letter, No. 51

Although plans aren’t definite, the House Interstate and Foreign Commerce Committee hopes to schedule hearings on health insurance for early January. The committee devoted two days to the subject in October, and adjourned with the understanding that it would complete its study after the first of the year. The contemplated hearings would look into all phases of pre-pay plans, including catastrophic illness insurance, and would hear selected representatives from the American Medical Association, cooperative health plans, labor, Blue Cross and Blue Shield, Health Information Foundation, the Committee for Economic Security and others.

STUDY OF PREMATURES

Dr. George H. Yeager
Editor
The Maryland State Medical Journal
1211 Cathedral Street
Baltimore 1, Maryland

Dear Dr. Yeager:

This open letter to the physicians of Maryland is a progress report on the Study of Prematures which is being carried out by the Division of Maternal and Child Health of the Johns Hopkins University with the endorsement of the Medical and Chirurgical Faculty and other groups.

A field investigation of retrolental fibroplasia is being conducted as a special part of this Study and is the primary subject of this letter. This new disease has become the chief cause of admissions to schools for the blind and this part of the Study has the particular endorsement of our Medical Advisory Committee, of the Ophthalmological Section of the Medical Society, of the Committee on Maternal and Child Welfare of the Medical and Chirurgical Faculty, of the Maryland Society for the Prevention of Blindness and of other groups.

Since the incidence of retrolental fibroplasia is highest in the smallest prematures, all babies of less than $3\frac{1}{2}$ pounds (1500 grams) birth weight are being visited by Dr. Rothmund, a member of our staff. In each instance, the consent of the family physician is secured through a letter about this part of the Study or through a telephone call or both.

The purpose of Dr. Rothmund's visit is to determine the presence or absence of any gross visual defects. Questions about general development are interspersed with those concerning vision, and simple tests such as the ability of the baby to see a small pellet are used as aids in diagnosis. Every effort is made not to arouse concern in the parents about the child's vision.

In addition to these visits to babies under $3\frac{1}{2}$ pounds, a brief questionnaire is being mailed to mothers of babies with a birth weight between $3\frac{1}{2}$ and $4\frac{1}{2}$ pounds. Whenever the mother's answers suggest any visual difficulty, the child is visited after prior contact with the family physician.

Ultimately, all children with eye defects suggestive of retrolental fibroplasia should be referred to an ophthalmologist for final diagnosis. Our consultants have advised that these examinations should all be done by four or five ophthalmologists in order to give uniformity of diagnosis and especially to obtain agreement upon the stage or degree of disease. A classification adopted by the National Committee on Retrolental Fibroplasia and published in the October 1953 American Journal of Ophthalmology is being used. This may mean that we will ask to have a repeat consultation on some babies who have already visited an ophthalmologist.

It now appears that about 35 to 40 babies throughout the state show enough evidence of visual difficulty to warrant consultation. We are aware that some of these infants have only minimal evidence of visual defect; others already have a diagnosis of retrolental fibroplasia but information about the stage of disease based on the above classification is not available; all of them meet our criteria for an ophthalmological consultation. In each case, we will call the family physician to obtain his approval and to arrange details. Each consultant will send his report to the family physician with a copy to the Study office. Pathology will not be discussed but parents of these children will be told that a report will be mailed to their family physician. There will be no charge for these consultations.

As of this writing, the following ophthalmologists have agreed to act as consultants: Dr. Angus MacLean, Dr. Arnall Patz, Dr. Frederic Reese and Dr. Roy Scholz of Maryland and Dr. Frank Costenbader of Washington, D. C.

I would now turn to a brief comment on the Study as a whole. It will be remembered that the Study has two aims: The first of these is to evaluate hospital care of prematures in terms of survival. As a result of excellent cooperation of physicians and hospitals throughout the state, data about hospital care and survival of nearly 5,000 prematures born in 1952 have been collected and are being analyzed. A report on this material should be ready in the next six months.

The second main purpose is to determine how many of those prematures who do survive develop normally and in what ways the other survivors are handicapped. This part of the Study requires a long term follow-up over ten or twelve years. The first phase of this long time investigation is a Gesell type of developmental examination done on about 500 prematures and 500 full term control babies in Baltimore City. These examinations are being done when the baby is about 40 weeks of age and are now nearly completed. Plans are being developed for the future follow-up of these 500 prematures and their full term controls and will be the subject of a later report.

We would again like to thank the physicians of Maryland for their cooperation and to say that questions or suggestions are welcome.

Sincerely yours,
Paul Harper
Paul Harper, M.D.

November 24, 1953

DEFENSE DEPARTMENT'S SCHOLARSHIP LEGISLATION IS ABOUT READY

The AMA Washington Letter—No. 47

Defense Department's draft legislation for medical and other federal scholarships is receiving a final checking over before presentation to the Budget Bureau for approval. Budget Bureau approval is necessary if the plan is to be presented as an administration bill, but regardless of the bureau's action, the proposal could be offered by any member of House or Senate. Essential provisions of the plan:

1. Any medical, dental, nursing, or veterinary student accepting a scholarship would be obligated for one year of federal service for each scholarship year.
2. Payment would be made directly to the schools for tuition and other incidentals and to the student to cover living expenses during the school year.
3. Scholarships, limited to four years, would not be offered to pre-medical students or others preparing for professional courses.
4. Deans would make recommendations, but final selection would be by the Defense Department.

According to a department spokesman, there are two objectives: First, to meet armed forces needs after expiration of the doctor draft in 1955, if the regular draft obligation does not produce enough officers. Second, to interest enough young officers in regular military careers to maintain the regular corps at the necessary level. Currently regular medical officers make up only about 25% of the medical corps total; it is hoped to reverse this ratio.

Scientific Papers

THE CLINICAL VALUE OF ARTERIOGRAPHY¹

E. CONVERSE PEIRCE, II, M.D.²

Many clinicians have little familiarity with the techniques of contrast visualization of the arteries of the body and suppose that they can get along quite well without them. They have heard that the procedures may be dangerous, producing thrombosis, hemorrhages or brain damage and have not felt that they would like to subject their patients to these hazards. Others have seen or made a few arteriograms and have been overimpressed by the beauty and clarity of the demonstrated arteries to such an extent that they have made examinations without much relation to the needs of the patient. Somewhere between these two extreme points of view lies the real clinical value of arteriography.

Recent advances in surgical treatment of aneurysms, arteriovenous fistulas, and arterial blocks have made imperative accurate preoperative delineation of the vessels in the region of the contemplated surgical procedure. In addition arteriography has been most helpful in the differential diagnosis of aneurysm and tumor in many areas. It has been a helpful adjunct in the evaluation of a few types of congenital cardiovascular disease and it shows promise of continued usefulness in the evaluation of renal and adrenal disease. In time I believe the various arteriographic methods will be very widely used. This paper will deal primarily

with the usefulness of arteriography without particular reference to its several methods.

Peripheral arteriography was first reported in 1923. It is a relatively simple procedure to perform but unless surgery is contemplated seldom gives information necessary to the care of the patient that cannot be obtained more easily by simple physical examination. Arterial blocks, aneurysms, and arteriovenous fistulas can be outlined, frequently providing information of great value to the vascular surgeon. Occasionally an arteriogram may make it possible to differentiate an atypical thrombophlebitis that mimics an arterial occlusion because of its profound vasospasm from an actual occlusion. It may also be possible to prove the presence of an occlusion when classical signs including pain and anesthesia are lacking.

Cerebral arteriography is a procedure of undoubted great clinical merit. It was reported by Egas Moniz in 1927 and the Nobel prize was awarded for this work in 1949. Cerebral arteriography is clearly indicated in cases of subarachnoid hemorrhage, and in many cases with intracranial space occupying lesions gives information on localization and type of lesion that is not otherwise obtainable. One possible advantage over air study is that it is not necessary to be prepared for immediate craniotomy in cases of tumor with increased pressure. Since the introduction of a percutaneous method and the use of dilute diodrast the procedure has been used very widely. There are clear cut dangers of brain damage, however, precluding the indiscriminate use of this examination.

Translumbar and catheter methods are valu-

¹ Presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, Wednesday afternoon, April 29, 1953, Osler Hall, Baltimore, Maryland.

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TABLE 1
Clinical Value of Abdominal Arteriography

Diagnosis and anatomical evaluation of vascular lesions
Aneurysms
Arteriovenous fistulas
Arterial occlusions
Pathological diagnosis of many renal lesions including:
Hydronephrosis
Tumors
Inflammation with destruction or perirenal abscess
Cysts
Vascular abnormalities
Malformations
Evaluation of parenchymal damage in kidney
Areas of decreased opacification in nephrogram
Decrease in calibre of arteries
Localization of functional adrenal masses
Pheochromocytoma
Adrenal cortical tumors
Adrenal hyperplasia
Assistance in evaluation of obscure masses
Location and size may be shown by aortic, renal or iliac displacement, etc.
Tumors may be identified by characteristic pooling of contrast medium or increased regional vascularity
If an organ such as kidney or spleen is involved this may be disclosed by its typical vascular pattern
Various organs may be excluded by having normal vascular patterns
Vascular obstruction by infiltrating tumor may be shown

TABLE 2
Clinical Value of Thoracic Arteriography

Differential diagnosis of neoplasm and aneurysm
Diagnosis and evaluation of acquired vascular lesions
Aneurysms
Dissecting aneurysms
Arteriovenous fistulas
Aortic regurgitation
Syphilitic aortitis
Diagnosis and evaluation of congenital vascular lesions, especially when obscure
Coarctation
Patent ductus arteriosus
Aortic septal defect
Arch anomalies
Aortic and subaortic stenosis

able for examination of the abdominal aorta. The areas in which the procedures may be useful are indicated in Table 1. In general arteriography is of greatest value in precise evaluation of lesions of the aorta and iliac arteries prior to

surgery and in this group of conditions there is no substitute for this examination. Recently adequate arterial visualization has rendered practical resection and grafting for aneurysms. Occlusions can be more adequately evaluated and treated. Occasionally valuable information pointing to the correct diagnosis and proper surgical approach has been obtained in the case of obscure abdominal and retroperitoneal masses. Adrenal tumors can sometimes be localized to the proper side greatly simplifying the surgical approach. Precise evaluation of renal lesions may be possible. Cysts have been distinguished from neoplasms, clinically significant aberrant vessels have been visualized, and parenchyma damaged by tuberculosis has been distinguished from adjacent normal tissue simplifying segmental resections. The use of arteriography in renal disease has been rather highly developed in a few centers although this is not its most remunerative field. These procedures have relatively little danger although a few complications are reported.

Angiocardiography and various direct catheter methods are suitable for evaluation of the thoracic aorta and its branches. Other methods have quite limited usefulness. The diagnostic value of the various procedures is indicated in Table 2. The differentiation of aneurysm from neoplasm or other extra aortic mass can be done only by arteriography in some cases. Adequate preoperative contrast studies permit necessary preparation to deal definitively with many aneurysms and at the worst may save the patient an unnecessary thoracotomy. Thoracic arteriography is very useful in the evaluation of a few complicated forms of congenital heart disease, especially patent ductus arteriosus with atypical murmurs or coarctation of the aorta presenting unusual clinical features such as absence of rib notching where the narrowed segment may be in an atypical location or long enough to require a graft. Thoracic arteriography by catheter entails the hazard of cerebral damage from the contrast material and consequently should not be undertaken unless the information

is really needed. Because of the diversity of thoracic problems those performing contrast studies in this area should be entirely familiar with the various available techniques and their hazards.

SUMMARY

Arteriography may be conveniently divided into cerebral, peripheral, abdominal and thoracic methods each differing considerably from the

others. Arteriography is the only definitive method for the study of many vascular lesions including occlusions, aneurysms, and arterio-venous fistulas. It is useful for studying tumors in many areas and is a desirable adjunct in the evaluation of certain cases of congenital cardiovascular disease. The various methods should be more widely used than is presently the practice.

PANEL DISCUSSION: BLOOD DYSCRASIAS¹

Introduction

CYRUS C. STURGIS, M.D., *Moderator*²

One of the greatest problems facing the medical profession at present is keeping abreast with current developments in medicine. I estimated from the examination of the Current List of Medical Literature the other day, that there are between 110 and 120 thousand medical articles written each year. A single person, of course, cannot read all those articles and even if we could read them it would be exceedingly difficult to evaluate many, particularly if they were not in some field in which we were working. Therefore, I think Panels

such as this are worthwhile because you can have a statement by someone who is an authority in the field as to what his opinion is in regard to certain important aspects of Hematology. Any one of the four men who are with me on the Panel could spend the entire evening speaking in the particular aspect of Hematology in which he is interested, but time, of course, does not permit this.

As a result, we have picked out five different topics, each one assigned to a member of the Panel, and we will start by giving fifteen minute talks on these special subjects. This will take 75 minutes. Then there will be a period of Questions and Answers and I hope you will send up some questions and we shall try to answer them.

So without further comment then, I wish to call on our first speaker, Dr. Norwood, who is to discuss Drugs and Chemicals Responsible for Blood Disorders, and we will hold him strictly to fifteen minutes

¹ Presented before the Baltimore City Medical Society on Friday, January 16, 1953, at the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore 1, Maryland.

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DRUGS AND CHEMICALS RESPONSIBLE FOR BLOOD DISORDERS

VERNON H. NORWOOD, M.D.

Dr. Sturgis, and members of the Baltimore City Medical Society.

In considering the subject of "Drugs and Chemicals Responsible for Blood Disorders," we find it difficult to attempt a comprehensive list of significant materials, since chemical and pharmaceutical research constantly offer new

products which may be a potential hazard, demonstrated only by extended use. However, we can consider some of the more commonly encountered substances which are recognized as significant at the present time. These substances may be chemicals to which the body is exposed incidental to daily life or occupation or

they may be products used for medicinal purposes. The drugs may be deliberately used for a known and constant effect upon the blood system or the hematological effects may be incidental to other actions or of only occasional occurrence. These latter compounds, which only occasionally cause trouble, are of greater significance since the unpredictable results may have grave consequences and frequently appear with little warning in the unsuspecting patient.

The effects upon the blood may involve the peripherally circulating blood, or more frequently the bone marrow as the site of blood formation and may affect principally the red cell elements or else the myeloid and platelet elements, or may affect all three together or in variable combinations.

Industrial exposure subjects the worker to many substances which are of a toxic nature, attacking the blood system frequently alone or in combination with action on other organs. Of such substances, Benzene (Benzol) has one of the most striking effects on the blood system. When used in pure form as a solvent for many commercial processes or occurring as a contaminant of other hydrocarbons, it produces a variable picture which always manifests itself ultimately as a profound anemia in which all elements of the blood are concerned. As with most substances encountered under these circumstances, a variable picture will be seen with emphasis upon destruction of white cells in one case and of red cells in another and invariably ending, in the most aggravated forms, as an extremely intractable aplastic anemia. In respect to this substance, as in the case of many drugs with which we are concerned, individual susceptibility appears to be important since experience has shown that the occasional individual will succumb to exposures which have no apparent effect on colleagues working under the same conditions.

Lead is a product encountered under many circumstances which besides affecting other

organ systems, often produces a significant anemia which appears to result from the effect of lead upon the peripherally circulating blood, without damage to the bone marrow. The result is, that in lead poisoning, evidence of regeneration is strong and an aplastic marrow is not likely to be encountered.

Anilinism, a comprehensive term to describe the effects of exposure to a large group of compounds of the same chemical family, including Aniline oil itself and the aromatic nitro and amino compounds of Aniline, are notorious for their effect on the blood, producing methemoglobinemia which results in a striking and characteristic cyanosis and in chronic cases, producing a considerable degree of anemia.

The nitrotoluenes and nitrophenols, some of which have been used in medicine, may produce either anemia or agranulocytosis.

Among drugs administered as therapy in blood diseases, which may affect the blood unfavorably, we may once again mention Benzol for its historic interest. Because it does destroy blood cells, Benzol has been used in the treatment of leukemia, producing a very effective reduction in total count. This, however, is an obsolete therapy at the present time, since the same effect may be accomplished by other means at a less risk.

Phenylhydrazine, used in the treatment of polycythemia, will drastically reduce the red cells by increasing their fragility and aiding in their removal from the circulation without affecting the bone marrow or significantly affecting the white blood cells. Used carelessly, it can produce a profound and dangerous degree of anemia.

Urethane used in recent years for treatment of leukemia, again produces its effects by a toxic action on the bone marrow, resulting in a reduction of the total white cell count and again must be used with caution to avoid excessive destruction.

Folic acid antagonists such as Aminopterin, used for treating malignant disease, must be

used with care since profound degrees of bone marrow depression with anemia and agranulocytosis result from their uncontrolled administration.

Nitrogen mustard, useful for malignancies and lymphomatous diseases, is interesting in that it may affect all blood elements, but has a particularly selective effect on the lymphocytes of the circulating blood.

Drugs used for other effects upon the body but producing occasional unfavorable action on the blood, next come under consideration. The first drug which should be considered, because of its historic significance, is the analgesic compound, Aminopyrine, which was ultimately incriminated as the cause of fatal cases of agranulocytosis, which began to appear in increasing numbers in the late 1920's. This new syndrome of complete disappearance of granulocytic cells from the circulating blood without effect on the hemoglobin or red cell count, and marked clinically by fever and the appearance of gangrenous ulceration of the oral mucous membranes, was first shown by Madison and Squier, to be related to the ingestion of Aminopyrine. This drug in either its pure form or administered in proprietary combinations and forms under the name of Pyramidon, Amytal Compound, Allonal, Cibalgin, Neonol, Peralga, and others, was used in tremendous quantities and a very significant point was quickly realized, namely that this drug was not toxic per se, but that an individual susceptibility played a part in the production of its dangerous effect. The same individual idiosyncrasy shows up in most of the drugs which have to be considered as potentially toxic to the blood forming organs.

Nearly all the barbiturate drugs used as sedatives, have been incriminated at one time or another, but such instances of blood damage are extremely rare from most of these compounds.

The introduction of a new analgesic at the present time is an extremely difficult problem for in the clinical and laboratory test periods,

one suspected incident of depression of white blood count, either in a laboratory animal or human patient, will scare off any further attempts on the part of the manufacturer, to promote his new compound. This has happened at least twice within the past two years, the abandonment of the experimental drug being based merely on suspicion and not on any proven damage produced.

The arsenic containing compounds used in the treatment of syphilis, have been occasionally the cause of purpura or aplastic anemia.

Thiouracil and its derivatives, used in the treatment of hyperthyroidism, have caused considerable trouble because of their occasional production of agranulocytosis. This has developed from all the variants upon the original drug, the frequency of its occurrence apparently being related to the size of the dose necessary for clinical effect and consequently being less frequent with the drugs which are active in smaller dosage. However, none to present date have been free from such action. The drugs introduced more recently for control of epilepsy, particularly Tridone, have as one of the penalties attached to its use, the requirement that a study of the blood be carried out to avoid the production of agranulocytosis.

Gold compounds used in the treatment of arthritis, may in addition to their toxic action on the liver and kidney, occasionally produce aplastic anemia of dangerous degree or an agranulocytosis.

The sulfa compounds with their saving of hundreds of lives which would have been lost from infection without their help, are however, capable of producing damage. Most striking was the action of sulfanilamide, the first compound introduced in therapy, which in an unpredictable 1-3%, would without warnings, suddenly produce a profound degree of hemolytic anemia, which bore no relationship to the almost constant cyanosis which accompanied its use. In addition to the hemolytic anemia, an agranulocytosis appeared in a smaller number of cases,

approximately 0.3%. The succeeding sulfonamide compounds became progressively less dangerous to the blood system, and at the present time, the compounds currently in use, give little concern in this regard.

Extremely disconcerting has been the discovery, during the past year, that one of the extremely valuable antibiotics, Chloromycetin, can be the cause of a profound and occasionally fatal anemia or agranulocytosis.

Most recently added to the list of potentially dangerous drugs, is the compound which is one of the most recent drugs introduced into therapy, namely, Phenylbutazone (Butazolidin) which is used for the treatment of gout and arthritis.

It is interesting and undoubtedly significant, in considering the structural formula of many of these compounds, to find that chemical relationship to Benzol in its ring structure, is found in many of these compounds. This was recognized for aminopyrine, and is to be found in Thiouracil, Phenylbutazone, and even in the only

antibiotic which has been synthetically prepared and exactly described chemically, Chloromycetin. It would appear that study of structure of new compounds might give some clue as to the possibility of their dangerous action.

In considering the use of these drugs, we must bear in mind that the unfavorable and destructive action occurs in a very minute fraction of the number of patients in which they are used. In the vast majority of instances, the action is the favorable one, which is desired. The unfavorable action, occurring once in 10,000 times, must not force from use, drugs which are irreplaceable in producing certain healing results. We must, however, recognize the importance of adequate supervision and recognition of the possibility for harm which such compounds do carry.

DR. STURGIS: Thank you, Dr. Norwood.

Until 1926, we had absolutely no means of treating the macrocytic anemias. In that particular year Minot and Murphy introduced liver and since then there has been a long series of important therapeutic developments including folic acid and vitamin B₁₂. Dr. Conley is to take this topic, which is "The Treatment of Macrocytic Anemias."

TREATMENT OF MACROCYTIC ANEMIAS

C. LOCKARD CONLEY, M.D.

Anemia is always a manifestation of disease and should never be looked upon as a disease itself. When the cause of anemia is not obvious, careful examination of the blood will often provide clues suggesting the nature of the disorder. Anemia characterized by macrocytosis of the red cells always brings to mind the possibility of a deficiency of either folic acid or of vitamin B₁₂. It is important to recognize that not all macrocytic anemias are attributable to deficiencies of these vitamins. An impressive macrocytosis is sometimes seen with other disorders of the hematopoietic system, as for example in certain aplastic and hemolytic anemias. The macrocytic anemia associated with folic

acid or B₁₂ deficiency is a very special type of disorder in that the bone marrow shows an abnormal megaloblastic change which is virtually pathognomonic of deficiency of one of these vitamins.

Folic acid and vitamin B₁₂ are chemically unrelated substances, both of which are required for normal health, growth and development. These vitamins are specifically required for blood formation. The metabolic actions of these vitamins seem to be very closely interrelated so that deficiency of one gives rise to a clinical disorder which simulates that produced by deficiency of the other. Thus the anemia and abnormal bone marrow pattern associated

with B₁₂ deficiency are indistinguishable from those produced by folic acid deficiency. Other clinical manifestations of the deficiency state are also similar. Deficiency of either vitamin may give rise to glossitis with soreness, redness, and papillary atrophy of the tongue as well as other alimentary disturbances including anorexia, nausea, vomiting and diarrhea. It is not always easy on clinical grounds to differentiate deficiency of B₁₂ from that of folic acid. Inadequacy of vitamin B₁₂ may give rise to a very characteristic disorder of the nervous system, namely subacute combined degeneration. This neurologic syndrome is not associated with lack of folic acid; therefore, the occurrence of subacute combined degeneration is always indicative of B₁₂ deficiency. The close metabolic relationships between folic acid and B₁₂ undoubtedly account for the similarity of the two deficiency states. Nevertheless one vitamin cannot supplant the other. It is of interest and importance, however, that a partial deficiency of one vitamin will seem to be overcome by administration of an excess of the other. Because of this fact the therapeutic test is often of little value in the differential diagnosis of these deficiency states.

Neither vitamin B₁₂ nor folic acid is a bone marrow stimulant. Its value as a therapeutic agent is limited to those conditions in which a deficiency of the vitamin is present. In anemias not attributable to vitamin deficiency administration of folic acid or B₁₂ is entirely without effect.

Folic acid deficiency may be brought about by inadequate intake of the vitamin or by defective absorption. In some areas of the world where the diet is grossly inadequate, folic acid deficiency is common. In India, for example, a macrocytic anemia attributable to folic acid deficiency has been frequently encountered. Numerous cases have been seen in certain areas of the southern United States. However, nutritional folic acid deficiency is virtually unheard of in the vicinity of Baltimore and one

should be very hesitant to suggest a diagnosis of nutritional macrocytic anemia in this area. Evidences of folic acid deficiency may occasionally appear during pregnancy, presumably at least in part because of increased demands for the vitamin at that time. The macrocytic anemia of pregnancy which is erroneously called "pernicious anemia of pregnancy" is a folic acid deficiency state. The anemia may be associated with glossitis and gastrointestinal disturbances. These manifestations promptly subside following the administration of folic acid. This disorder is extremely rare in this vicinity. We have seen only 2 cases at the Johns Hopkins Hospital in 5 years. The disorder can be prevented by the prophylactic administration of supplementary folic acid. In view of the great rarity of the condition, it is a question whether folic acid, an expensive substance, should be administered routinely to all pregnant women. Folic acid deficiency, particularly when associated with deficiency of vitamin C, has in rare instances been observed to produce a macrocytic anemia in young infants. This disorder has most often occurred in infants who had inadequate diets and superimposed febrile illnesses. There is good evidence that vitamin C may be concerned with the conversion of folic acid to a biologically more active substance and it is probably for this reason that the combined deficiency is found in infants with this type of megaloblastic anemia. The most common cause of folic acid deficiency which we see is defective absorption of the vitamin from the small intestine. This impaired absorption is most often associated with sprue, a disease in which there are multiple absorption defects. Occasional cases of extensive regional enteritis may also lead to defective absorption of folic acid and a resultant macrocytic anemia. Administration of folic acid to such patients rapidly overcomes the manifestations of folic acid deficiency, but, of course, does not cure the underlying disease. You will note that conditions causing folic acid deficiency are very

uncommon in this part of the world and we do not often have occasion to employ this vitamin therapeutically. When folic acid deficiency is present the oral administration of about 5 mg. per day is usually adequate for satisfactory therapeutic effect. In patients with serious absorption defects it is probably wise to give somewhat larger doses.

Vitamin B₁₂ is a very remarkable substance, deficiency of which gives rise to the manifestations of pernicious anemia. Theoretically, vitamin B₁₂ deficiency could be produced by inadequate diet. However, if such a deficiency occurs at all, it must be extraordinarily rare. The fantastically minute amount of the vitamin which is required, together with the production of B₁₂ by intestinal bacteria, probably account for the rarity of nutritional deficiency states. Pernicious anemia is the syndrome of vitamin B₁₂ deficiency. All of the manifestations of this disease can be attributed to failure of adequate absorption of vitamin B₁₂. The mechanism by which vitamin B₁₂ is absorbed from the gastrointestinal tract seems complex. In order that optimal absorption can take place, an as yet unidentified component of the gastric secretion is required. This gastric component is the old "intrinsic factor" of Castle, while vitamin B₁₂ itself is now considered to be the "extrinsic factor" of Castle's hypothesis. The basic disorder in pernicious anemia is an abnormality of the gastric mucosa as a result of which normal gastric secretion is not produced. For this reason, patients with pernicious anemia have no hydrochloric acid or gastric enzymes in the stomach. Lack of these substances has no clinical effect. However, the deficiency of "intrinsic factor" leads to impaired absorption of vitamin B₁₂ as a result of which manifestations of B₁₂ deficiency eventually appear.

The macrocytic anemia, the alimentary symptoms, the neurological manifestations are all specifically attributable to deficiency of B₁₂. There is no regular time relationship of the appearance of the various symptoms. Thus glos-

itis or neurological manifestations may appear before the blood becomes abnormal. The term "pernicious anemia" is no longer an appropriate designation for the disease, for the disorder is not pernicious, and we recognize now that it is not primarily an anemia. The treatment of pernicious anemia is extraordinarily simple. Since vitamin B₁₂ is poorly absorbed from the intestine, the absorption defect is circumvented by parenteral administration. Amazingly small amounts suffice. In our experience with a large group of cases, the injection of 45 micrograms of B₁₂ at intervals of 6 weeks has in every case been adequate to maintain complete hematologic and clinical remission for periods of observation which in some cases now exceed four years. During the initial phase of treatment it is advisable to give larger and more frequent doses, particularly when neurologic manifestations are present. The alimentary symptoms subside in a day or two after therapy is initiated. The blood returns entirely to normal within a few weeks, but neurologic changes are unpredictably benefited. If treatment is delayed, permanent neurologic damage may result. It is important to remember that the therapy must be continued for the life of the patient. If treatment is discontinued, relapse will eventually occur. Parenteral therapy is so simple, so completely effective, and so inexpensive, that it seems unwise for physicians to experiment with oral therapy. Vitamin B₁₂ can be absorbed from the intestine of patients with pernicious anemia if adequately large amounts are given. However, the amount required is of the order of 100 times the effective parenteral dose. The administration of a source of intrinsic factor with vitamin B₁₂ enhances absorption and makes possible the use of smaller oral doses. Such preparations are now appearing on the market, but they have not as yet been subjected to long term clinical trial.

Although pernicious anemia is a vitamin B₁₂ deficiency state, administration of folic acid will often produce striking clinical and hematologic improvement in patients with this disease. How-

ever, folic acid does not bring about improvement of the neurologic disorder, which often progresses rapidly during folic acid therapy. When folic acid is administered to patients with pernicious anemia, the blood may remain entirely normal and the only evidence of the disease may be progressive subacute combined degeneration. Because of the widespread use of folic acid in multivitamin preparations, patients with pernicious anemia are appearing with advanced neurological disease in the absence of anemia. The syndrome of subacute combined degeneration should always be considered to be a manifestation of pernicious anemia and should be treated as such, even though the blood and bone marrow are normal.

Vitamin B₁₂ deficiency is rare apart from Addisonian pernicious anemia. Occasional patients develop typical pernicious anemia following total gastrectomy, presumably because the source of intrinsic factor has been removed and vitamin B₁₂ is then poorly absorbed. Rarely

patients with intestinal absorption defects such as occur in sprue may develop evidence of B₁₂ deficiency. An interesting group of patients has been observed in which B₁₂ deficiency has been associated with certain lesions of the small intestine such as diverticulae or resection of a portion of the intestine. The clinical manifestations which these patients present are similar to those of pernicious anemia, except that the gastric secretion may be normal. Treatment is the same as for pernicious anemia.

Conditions in which there is a combined deficiency of both folic acid and B₁₂ are rare. In my opinion, the only condition for which one is regularly justified in administering both vitamins is sprue, a disorder in which multiple deficiency states appear. Except for the conditions which I have mentioned in this discussion, there is little well established indication for the use of folic acid or vitamin B₁₂.

DR. STURGIS: Thank you, Dr. Conley.

HEMOLYTIC ANEMIA

MILTON S. SACKS, M.D.

An understanding of certain physiologic facts about the life span and survival of the red blood cell is fundamental for any discussion of hemolytic anemias. It is now generally agreed that the normal red cell survives in the peripheral circulation for approximately 100 to 120 days. Whenever there is accelerated destruction for one reason or another a hemolytic anemia may ensue. The tempo of destruction determines the clinical picture. Thus the picture may vary from an acute hemolytic anemia due to massive red cell breakdown with associated hemoglobinuria to a subacute process or to one which is of relatively slow tempo and which is characterized as a chronic hemolytic anemia.

Much of the information which we have about the life span of red blood cells is based

upon the technique proposed a number of years ago by Winfred Ashby. Although there have been modifications of the Ashby technique the principle has been retained. It consists, in essence, of introducing red cells which are antigenically different from those of the recipient but yet which will not produce any reaction. One may follow the survival of these "tagged" red cells in the recipient's blood.

A recent extension of the Ashby technique has been the cross transfusion experiment by means of which it is possible to more or less pinpoint the site of difficulty. If one is dealing with a hemolytic anemia in which the basic defect is within the red cell itself, these abnormal cells will show an accelerated breakdown in the circulation of a normal individual; con-

versely, a defect outside the red cell i.e., in the serum can also be detected.

On the basis of the foregoing data, one may attempt to classify this very large and complex group in the following manner.

The intrinsic group includes those hemolytic anemias in which there are hereditary defects in the red cell (Sickle Cell Anemia, congenital hemolytic jaundice, Mediterranean anemia). Hemolytic anemias of extrinsic origin include those due to chemical or physical agents, such as Dr. Norwood referred to, those due to bacterial infection (*Clostridium Welchii* sepsis); and a very large group in which there is apparently an autoantibody capable of reacting with the individual's own red blood cells.

It is, of course, impossible to go into considerable detail about all of these entities, so that I have chosen simply to comment on certain significant aspects of the hemolytic anemias which I consider important.

One interesting development of recent origin has been the characterization of hemoglobins in the various hereditary hemolytic syndromes. Studies on sickle cell disease by means of electrophoresis have demonstrated the existence of an abnormal hemoglobin in the red cells of these individuals. This type of hemoglobin is designated Hemoglobin S. Several related abnormal varieties have also been discovered. The clinical significance of these findings still remains to be determined.

In regard to congenital hemolytic jaundice, the importance of family study, cannot be over emphasized. A common clinical experience with regard to this disease and one emphasized many years ago is the aphorism that "these patients are more jaundiced than ill." Patients with congenital hemolytic jaundice are not infrequently seen who have reached middle age with virtually no clinical difficulties. A very important question arises with regard to these patients which might be phrased "to splenectomize or not to splenectomize." There are many advocates of prophylactic splenectomy even in such cases. The occurrence of repeated

hemolytic crises is an important indication for splenectomy.

We have been interested in certain of the genetic aspects of sickle cell anemia. The incidence of the sickling trait in the American negro is approximately nine per cent. It is of great interest that careful studies in scattered areas of the African continent have indicated an average incidence of the sickle cell trait of approximately fourteen per cent. In other words, in a period of some three hundred years there has been a gradual diminution in the incidence of the sickle cell trait in this country.

It needs to be emphasized that this disease occurs in at least two clinical forms, as the trait and as the active disease itself. When the gene responsible for this abnormality is present in a heterozygous manner the affected individual exhibits only the sickle cell trait. When it is present in the homozygous state, the active disease will result.

An important development in the diagnosis of this disease is the use of a reducing agent for the rapid demonstration of the sickling phenomenon. Sodium meta bisulfate is one of the most convenient and useful agents for this purpose. By this technique it is possible to obtain an answer within some fifteen minutes.

Mediterranean anemia, as you know, also exists in two forms. One, which is usually referred to as *Thalassemia Minor*, often exists without clinical symptomatology. The abnormal gene when present in a double dose (homozygous) results in the entity *Thalassemia Major*. In our experience this disease is most commonly seen in this country in individuals of Italian or Greek ancestry. It is of considerable interest to note that within recent years instances of sickle cell anemia in white individuals, usually of the latter ancestry have been described.

In the study of large family groups there is evidence that one may encounter both the sickle cell trait and the Mediterranean anemia trait in various members of the group.

I should like briefly to review the hematological and biochemical characteristics of the hemolytic anemias. The anemia is usually of a normocytic, or occasionally macrocytic type. The leukocyte count is usually normal. It may be increased in the presence of a crisis. Platelets are usually normal although there is an interesting group of cases of acquired hemolytic anemia in which thrombopenia and anemia have been observed together. The marrow usually shows there is a compensatory erythroid hyperplasia of a normoblastic type. Osmotic fragility is usually increased. An examination of the blood smear will reveal polychromatophilia, the presence of spherocytes, and frequently a significant normoblastosis.

The biochemical features include hyperbilirubinemia due to the indirect type of bilirubin. Occasionally, immediately after an acute massive hemolysis, there will be hemoglobinemia and hemoglobinuria. The urine and feces show increased urobilinogen excretion.

In the group of acquired hemolytic anemias are included all the entities exclusive of the hereditary syndromes. In actual practice, the term acquired hemolytic anemia has been considered synonymous with the type associated with an auto-antibody. The acquired types do, however, include those due to chemicals, drugs, bacterial infections, etc. I should like to place greater stress on those with a basic immunologic disorder. Even within this group there are a variety of types. One type, known for a long time, is the paroxysmal cold hemoglobinuria associated with some cases of lues. The mechanism of this type was described many years ago and is embodied in the classical Donath-Landsteiner Test. By this procedure one can demonstrate an antibody present in the individual's blood which is capable of uniting with his own cells at low temperatures. Hemolysis occurs with raising of the body temperature.

During the past five or six years a great deal of work has been done on the pathogenesis of

acquired hemolytic anemia due to the presence of an auto-antibody which unites with the patient's own erythrocytes. The Coombs' test, introduced about 1947, has offered a means of demonstrating this antibody adsorbed on the red blood cell. The antibody is now recognized to be a panagglutinin capable of reacting with virtually all normal human cells. It may be one which is most active at 37° C. (warm agglutinin) or one which is most active at refrigerator temperature (4° C.). We believe the type of antibody, warm or cold agglutinin, may actually determine the clinical syndrome. For example, in primary atypical pneumonia, an occasional case of acquired hemolytic anemia associated with a high type of cold agglutinins is sometimes seen. This type of acquired hemolytic anemia usually has a better prognosis than the type associated with a warm agglutinin.

Of particular interest in our study of acquired hemolytic anemia is the recognition that the hemolytic anemia may occur only as a complication of some other underlying disease. In a review of the literature of the past 10 years it was interesting to note that of eighty-five cases of secondary acquired hemolytic anemia most were associated with primary atypical pneumonia, various types of lymphoma, and certain collagen diseases, notably acute disseminated lupus erythematosus.

The management of acquired hemolytic anemia can only be touched upon briefly in the time remaining. Cortisone and ACTH often cause dramatic remissions in these cases. Relapses are, however, common. Splenectomy should be employed when medical therapy fails. Unfortunately, it also is not uniformly successful. Recently, nitrogen mustard has been employed in an effort to produce a "medical splenectomy." The prognosis in this disease has been definitely improved by these measures. Much still remains to be done.

DR. STURGIS: Thank you, Dr. Sacks.

Our next speaker will be Dr. Cooley, who will discuss the Therapy of Leukemia, Hodgkin's Disease and Allied Disorders.

THERAPY OF LEUKEMIA, HODGKIN'S DISEASE AND ALLIED DISORDERS

ROBERT N. COOLEY, M.D.

The present day treatment of leukemia, Hodgkin's disease and allied disorders depends in large part upon the administration of agents which are toxic to the abnormal cellular growths which are the main feature of these diseases. Whether it be radiation, aminopterin, urethane or nitrogen mustard, all of these substances have a direct toxic or destructive effect upon the abnormal cells originating primarily in the bone marrow, spleen and/or lymph nodes. Unfortunately these agents have a similar action upon the normal cells of these same organs and the differential of susceptibility between the healthy and the neoplastic* tissue is small. For this reason present day therapeutic agents cannot be pushed to the point of complete destruction of all abnormal tissue growth for fear of irreparable damage to the essential normal tissues such as the bone marrow and the lymphatic system. Therefore, except under certain rare circumstances where the disease is well localized and easily accessible, cure is impossible and the best that can be expected is prolonged palliation.

The ideal therapeutic agent should have a highly selective destructive action on the abnormal cellular tissues and a relatively mild and benign effect on the surrounding normal organs. Another line of attack might be an agent, hormonal in nature, which would curb the otherwise unregulated neoplastic-like tissue growth and make it again subject to the usual growth restraints which the body provides naturally. Such agents are ACTH and Cortisone and more will be said about these by another essayist on this panel. Unfortunately the action of ACTH and Cortisone is often unpredictable and may be short lived and evanescent. The ideal treatment agent has not yet emerged.

Acute leukemia, untreated, is a rapidly pro-

* "Neoplastic" is used advisedly since there is still some dispute as to whether Hodgkin's disease and the leukemias are true neoplasms.

gressive disease which terminates fatally in one to six months. Radiation therapy is of almost no benefit and it is the opinion of several observers² that it may hasten the inevitable fatal outcome. Rarely, however, when massive enlargement of lymph nodes or collections of leukemic tissue produce tracheal obstruction or cardiac embarrassment, radiation may be directed toward these masses with the hope of reducing their bulk. Under these circumstances the dose must be small in order to 1) avoid further initial swelling of the masses and 2) prevent injury to an already badly damaged hemopoietic system.

Aminopterin and related anti-folic acid compounds have been in use for several years and it has been well established that following their proper use 60% of children and 20-30% of adults with acute leukemia will be improved. Occasionally the response has been striking and moribund children have been restored to a seemingly normal state. More often, however, there has been a gradual recession of the clinical signs and symptoms associated with a decrease in the number of abnormal circulating elements in the blood and bone marrow. Following a remission an attempt may be made to establish a maintenance dose, but the patient must be closely observed because of the marked toxicity of the anti-folic substances. The most pronounced of these effects are 1) injury to the bone marrow and 2) injury culminating in destruction of the surface epithelium of the digestive tract. One of the earliest manifestations of a toxic effect is soreness of the tongue and soft palate followed by ulceration and this is an urgent indication to suspend the use of the medication. Eventually these patients relapse, become refractory to the drug and succumb to leukemia or one of its complications. There can be no doubt, however, that the survival period,

of those patients who respond, is lengthened and that aminopterin or one of its associated compounds is the drug of choice in most cases of acute leukemia.

Like aminopterin, ACTH and Cortisone produce their most favorable effects in children with acute leukemia; of those about one-half will respond favorably. In adults less than 10% show any demonstrable improvement. Although these substances have been in use for some years they are still in an experimental stage and should be used only by those physicians who are familiar with their potentialities and dangers.

In chronic leukemia again we are dealing with an incurable disease which eventually terminates fatally. Treatment is therefore palliative and results are measured by 1) duration of life and 2) duration of comfortable productive life. A number of older surveys^{2, 7, 14} have shown that following the development of symptoms due to chronic myelogenous leukemia the average duration of life is about 3 years. In a significant study Minot⁷ and his associates found 52 cases of chronic myelogenous leukemia who had received no radiation or other specific therapy in which the duration of life following the onset of symptoms was 3.04 years. This was compared with a duration of life of 3.5 years in 72 patients with the same disease treated by x-rays. A summary of similar findings recorded by other observers² is shown in Figure 1 and this suggests that radiation produces only a very short and insignificant prolongation of life. However, all observers agreed that x-ray treated patients were definitely more comfortable and productive than those who received no specific therapy. Also more recently Osgood⁹ and Seaman found that more than 80% of the residual life of their radiation treated patients was spent in productive activities. Also Lawrence^{4, 5} and his co-workers have found average survival times of 3.7 years in chronic myelogenous and 4.1 years in chronic lymphogenous leukemia treated with radioactive phosphorus. Furthermore sev-

eral patients in each group are still alive. Consequently, there can be little doubt that radiation therapy in experienced hands has greatly improved the period of comfortable existence and slightly increased the actual longevity of patients with chronic leukemia.

The most commonly used chemical agents in the treatment of chronic leukemia are arsenic, urethane, triethylene melamine and nitrogen mustard. Wintrobe and Hasenbush¹⁴ found that arsenic was definitely inferior to roentgen therapy in the production of satisfactory remissions and this is the opinion of other observers.² Urethane may produce very satisfactory remissions and can be used as a primary means of treatment. However its effects are not easy to control and the margin between therapeutic and toxic dosages is quite narrow. Triethylene melamine and nitrogen mustard have a small field of usefulness in cases which are refractory to radiation. As a primary form of treatment they are somewhat less reliable and more difficult to control than radiation therapy.

Currently there are two radiation modalities, namely: 1) external x-rays administered a) locally to the spleen or less frequently to the liver or mediastinum and b) whole body radiation; 2) radioactive phosphorus administered by mouth or vein. None of these has clearly demonstrated its superiority over the other as a means of administering radiation. Of much

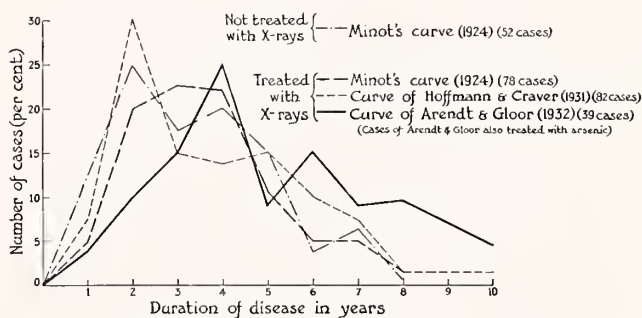


FIG. 1. Chart showing the duration of life in 4 series of cases of chronic myelogenous leukemia treated as indicated. Reproduced from, "Leukemia and Allied Disorders." The MacMillan Co., New York, 1938. By courtesy of Dr. C. E. Forkner, author.

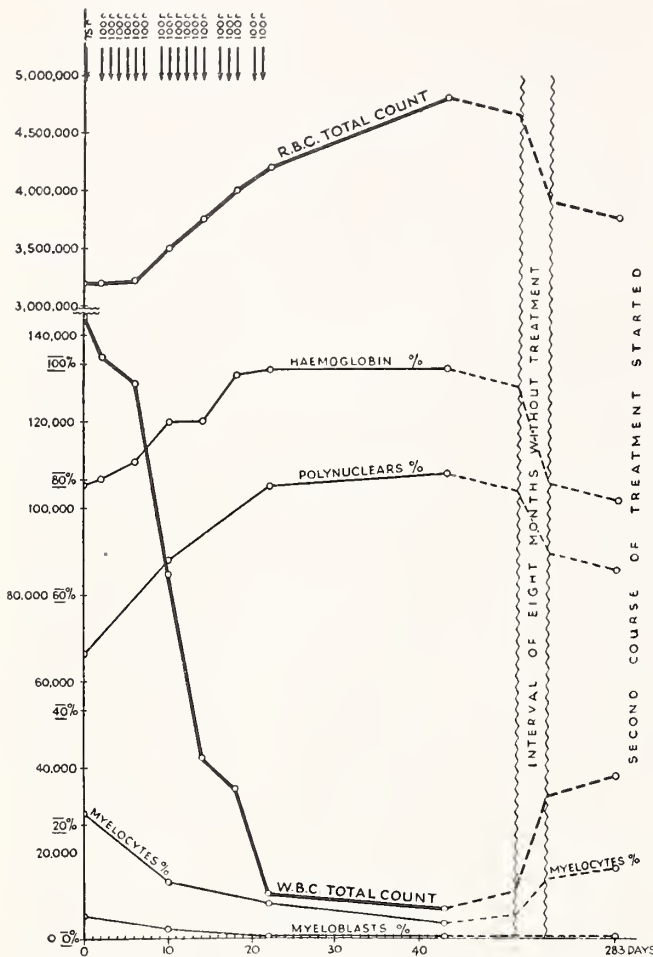


FIG. 2. Chart showing blood changes following administration of x-radiation to the spleen in chronic myelogenous leukemia. Reproduced from, "The Treatment of Malignant Disease With Radium and X-Rays," by R. Paterson.

greater importance is the amount and timing of the radiation rather than the means by which it is given. However, a review of seven recent papers^{1, 4, 5, 6, 9, 12, 13} indicates that a majority of the authors preferred radioactive phosphorus particularly in chronic myelogenous leukemia. Where external x-ray therapy was mentioned whole body radiation was preferred. However, where the spleen is greatly enlarged and is producing symptoms local radiation will reduce the size quicker and is therefore preferable. Radioactive phosphorus in the usual doses rarely produces radiation sickness in contrast to an incidence of 10–20% of this condition in patients receiving splenic irradiation. The practice at The Johns Hopkins Hospital is to ad-

minister x-radiation to the site of the largest collection of leukemic tissue which is often the spleen and less commonly the liver, mediastinum or cervical areas. If there are no large localized collections whole body radiation is given. The radiation should be administered in small daily doses until the blood count begins to drop significantly following which treatments are given every second and finally every third day until the white blood count approaches 20,000. At this point treatments are suspended and the count usually stabilizes in the neighborhood of 10,000. The principle effects of the radiation are to (Fig. 2): 1) reduce the total white blood count; 2) reduce the number of immature cells in the peripheral blood; 3) increase the red count, hematocrit and hemoglobin. Accompanying these blood changes there is usually a clinical remission in the patient's disease.

Following the initial course of treatment the patient should be followed at four to six weeks intervals. At the first sign of renewed leukemic activity such as an increasing white blood count, weakness, anemia or weight loss further radiation treatment should be considered. Further deterioration of the patient's condition should not be permitted because of a mistaken idea that treatment will be more effective under such circumstances. Eventually the disease will become refractory to radiation and this remains one of the unsolved problems in the treatment of leukemia. When the disease becomes refractory to one form of radiation, another may be tried such as a switch from splenic irradiation to whole body irradiation. Nitrogen mustard or triethylene melamine also may be tried. During the later refractory stages, however, the disease tends to become rapidly progressive despite all forms of treatment.

Anemia, which is a rather consistent feature of chronic leukemia, is best treated by blood transfusions. In general, if the hemoglobin is below 10 grams transfusions are indicated and are preferably given before the patient is sent for radiation therapy. Although not proven, it is

a clinical impression that those patients who have had their anemia corrected are less susceptible to radiation sickness and in general tolerate their radiation better than those who are anemic. Following successful treatment the anemia tends to improve spontaneously, but this is a slow process and is not sufficient when the anemia is well marked.

One should be especially alert for the onset of infections since leukemic tissues are particularly susceptible to bacterial invasion. Chronic infections likewise should be suspected and searched for. The free use of antibiotics such as penicillin is most helpful in dealing with these possibilities.

Several important observations have had an effect on current thought regarding the treatment of Hodgkin's disease and lymphosarcoma. These are: 1) A number of patients have survived for 10 years or longer following treatment; 2) in a majority of these patients the disease was limited to one set of nodes in the cervical region and was treated by surgery or obliterative x-ray therapy or both; 3) lymph nodes of Hodgkin's disease removed following the administration of 3000 roentgens of x-radiation in 4 weeks may show a severe damage or death of all cellular structures and 4) the best reported results have been obtained by vigorous radiation treatment to both the lymph node group in which the disease was first manifest and the adjacent lymph node areas. These observations might lead to the following assumptions: 1) the disease initially is a localized process in a single lymph node group and if treated vigorously while still localized, the disease might be obliterated; 2) the disease spreads by extension to adjacent lymph node areas so that inclusion of these areas in the field of radiation would improve the chances of reaching all of the disease. These assumptions are by no means proven. However, our current practice in patients with involvement of only one group of nodes or preferably a single node in the cervical region is to give obliterative radiation (3000 r.

in 3-4 weeks) to this area followed by considerably smaller doses (1000 r.) to the opposite cervical and mediastinal nodes. The same plan might be applied to a single axillary node. Primary involvement of other lymph node groups, however, such as the mediastinum or inguinal region, provide such a wide area of possible dissemination that such a treatment policy is impossible.

Slaughter and Craver¹¹ found a five year survival of 17.7% in a group of 265 patients with Hodgkin's disease treated mainly by x-radiation. On the other hand, Peters¹⁰ found that out of 113 treated patients 48 survived 5 years or longer. She classified her results according to the extent of the disease when treatment was begun.

	5 yr. sur- vival	10 yr. sur- vival
Stage I—Involvement of a single lymph node region (35 cases).....	88%	79%
Stage II—Involvement of two or more proximal lymph node regions of either the upper or lower trunk (32 cases).....	72%	21%
Stage III*—Involvement of two or more lymph node regions of both upper and lower trunk (46 cases).....	9%	0%

* More than 90% of the stage III cases had constitutional symptoms when first seen.

The extent of the disease at the time treatment was begun was thus shown to be one of the most important factors in determining the ultimate length of survival. The presence of constitutional symptoms in particular indicated a rather poor prognosis. Peters was inclined to attribute good results in part to the plan of radiation treatment which was followed. This consisted of intensive irradiation of involved nodes with precautionary treatment to adjacent lymph node groups.

Unfortunately, in Hodgkin's disease as it is seen today, more than 70% of the patients are in too advanced a stage to benefit from radical therapy. Therefore, in this larger group treatment is conservative and the primary objective is to make the patient comfortable. Even

though the disease may involve several lymph node areas x-radiation may still be the treatment of choice. However, where many groups of nodes are involved, or when the nodes are not easily accessible or easily localized as in the retroperitoneal region, or when there are marked constitutional symptoms, nitrogen mustard may provide quicker and more satisfactory relief. Also the judicious use of nitrogen mustard may materially reduce the number of x-ray treatments necessary to reduce the size and extent of widespread lymphadenopathy. Eventually most of these cases become refractory to radiation and nitrogen mustard therapy is indicated. Unfortunately remissions produced under such circumstances are usually of short duration.

Lymphosarcoma, reticulum cell sarcoma and giant follicular lymphoblastoma are radiosensitive tumors although they vary considerably in their response to treatment and in their prognosis. Initially they appear to originate in a single node or group of nodes. After varying periods of time they tend to spread to adjacent lymph node areas and then may become widely disseminated throughout the body. Treatment problems are therefore similar to those of Hodgkin's disease. Regional treatment may be given to cervical, axillary or inguinal regions in which an attempt is made to administer 2500-3000 roentgens to both the primary site of the disease and the surrounding lymph node areas. However, if the disease is recurrent following previous treatment or is initially quite extensive, smaller doses are given to each local area of involvement, the main objective being to produce palliation. Nitrogen mustard is somewhat less effective than when used in Hodgkin's disease, but is sufficiently valuable to be used when there is 1) refractoriness to radiation, 2) diffuse or generalized disease and 3) poorly defined or relatively inaccessible tumor masses.

Treatment in general is not satisfactory as less than 40% of patients will survive 5 years or longer. Reticulum cell sarcoma probably has

the worst outlook since this condition responds poorly to both radiation and nitrogen mustard. Lymphosarcoma in children runs a rapidly progressive course. In older individuals the course is variable and somewhat unpredictable. Numbers of long term survivals have been observed. Giant follicular lymphoblastoma, by virtue of its slow natural course and its marked radiosensitivity, gives by far the best prognosis. The average duration of life in this condition is about six years and death is often due to a supervention of Hodgkin's disease of lymphosarcoma.

SUMMARY

The present day treatment of leukemia, Hodgkin's disease and allied disorders is mainly palliative because: 1) the tendency of these diseases to become widely disseminated before treatment is begun; 2) most treatment agents are toxic or destructive to normal organs and consequently cannot be given in sufficient dosage to permit complete destruction of all abnormal or neoplastic tissue.

The average duration of life of treated chronic leukemia following the onset of symptoms is about $3\frac{1}{2}$ -4 years. Numbers of long survivals have been observed and are not unusual. Following proper treatment about 80% of the residual life of these patients will be spent in comfortable, productive activity.

In Hodgkin's disease and lymphosarcoma the average duration of life is about 3 years, but numbers of long term survivals have been observed. Treatment may produce satisfactory short term palliation. Occasionally treatment may be responsible for a long term survival and aggressive radiation treatment of well localized Hodgkin's disease has given some encouraging results and seems to be justified.

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DR. STURGIS: Thank you, Dr. Cooley.

ACTH AND CORTISONE IN THE TREATMENT OF HEMATOLOGIC DISORDERS

CYRUS C. STURGIS, M.D.

There is no convincing evidence that ACTH or cortisone permanently cures any disease by removing its underlying cause. On the other hand, they may produce prolonged remissions in some pathologic states, or so alter the situation temporarily that other curative factors may become effective. In certain hematologic conditions, these agents exert a salutary effect and serve a useful purpose, although with the exception of some cases of idiopathic thrombocytopenic purpura and possibly a rare case of idiopathic acquired hemolytic anemia, there is no indication that they are controlled permanently.

THE EFFECT OF ACTH AND CORTISONE ON THE NORMAL CIRCULATING BLOOD

First, let me make a few remarks concerning the effects of cortisone and ACTH on the normal constituents of the circulating blood. When 25 milligrams of ACTH are given subcutaneously,

there is an almost immediate decrease in the number of circulating eosinophils, which is sometimes followed by a rebound, and then a fall within four to six hours after the injection. These changes occur so regularly that they have been employed as a functional test of the adrenal cortex. With continued administration of this agent, there is usually a persistent absence of the eosinophils from the blood stream. This eosinopenia is the most constant change in the circulating blood following the administration of ACTH or cortisone. Hence it is the most reliable indication of the intactness of the adrenal cortex, if this decrease in the numbers of eosinophils follows ACTH injection. It is thought that the reduction in eosinophils is due to an inhibition of the rate of formation and release of these cells from the bone marrow, rather than to their accelerated destruction after they have reached the circulating blood.

Other changes also are observed in the peripheral blood following the administration of these

agents. They are as follows: A slight reduction of lymphocytes occurs usually within four hours after the injection of 25 milligrams of ACTH and this is followed by a moderate lymphocytosis often associated with the appearance of a few immature lymphocytes. Immediately after the injection there may be a slight transient fall in neutrophils, followed within one to four hours by an increase in the number of these cells, which reaches a maximum within 48 hours. This is of some interest because of the possible beneficial effects these therapeutic agents may have in the treatment of agranulocytosis. In summary, ACTH or cortisone produces an eosinopenia, a decrease in the number of circulating lymphocytes, and an increase in the total leukocyte count of the neutrophils. In the normal person, there might be a slight actual increase in the number of red blood cells and platelets but these changes are of minor importance and they may be obscured by dilution effects.

DOSAGE AND MODE OF ADMINISTRATION OF ACTH AND CORTISONE

In all of our patients, we have given either ACTH in doses of 25 milligrams subcutaneously every six hours or cortisone orally 75 milligrams every six hours. Usually such therapy has not been continued longer than 14 days although occasionally the period has been extended to 21 days. When a maintenance dose has been given, it has been restricted to a maximum of 75 milligrams a day. In all instances the patient has received a low sodium (800 milligrams) diet during the period of ACTH or cortisone administration. No important untoward symptoms have been observed during the course of therapy.

THE EFFECTS OF ACTH AND CORTISONE IN VARIOUS HEMATOLOGIC CONDITIONS

In the remainder of the time allotted to me, the discussion will be limited to the effects of ACTH and cortisone in the treatment of the

following conditions: idiopathic thrombocytopenic purpura, acute acquired hemolytic anemia, leukemia, multiple myeloma, Felty's syndrome and Hodgkin's disease. With the possible exception of acute agranulocytosis, in which it may be of some therapeutic value, there are no other hematologic disorders in which it exerts an appreciable beneficial effect.

IDIOPATHIC THROMBOCYTOPENIC PURPURA

In the past, patients with this condition either continued to suffer from the disease, succumbed to its effects, experienced a spontaneous remission, or were subjected to a splenectomy which proved to be curative in about 80 per cent of the group so treated. With the introduction of ACTH and cortisone, however, a new and useful agent has been made available for this condition. We have now treated 22 patients with one or the other of these two drugs and in 93 per cent a remission has followed within two to three weeks. The improvement in some patients has not always been complete but in every instance the platelets have increased to at least 75,000 per cubic millimeter and the excessive bleeding has been controlled.

In our group, when a remission has been produced, usually after two weeks of medication, the drug has been omitted and the patients kept under observation. In 60 per cent of these patients there has been a relapse in the bleeding tendency within 7 to 14 days, and splenectomy has been performed with satisfactory results after a second therapeutic remission has been produced either with cortisone or ACTH.

In 40 per cent of the patients after a therapeutic remission has followed the use of either one of these drugs, it has been maintained without additional treatment to the present time which provides a follow-up period varying from a few months to a maximum of two and one-half years.

In summary, it is certain that a remission, partial or complete, will be induced in prac-

tically all patients with idiopathic thrombocytopenic purpura by the administration of ACTH or cortisone. In 40 per cent of such patients, the improvement is of long duration and may be permanent. In 60 per cent, there is a rather prompt relapse, but a second remission can be induced preoperatively, which is a great advantage because splenectomy can then be performed with less risk as the bleeding tendency is controlled.

IDIOPATHIC HEMOLYTIC ANEMIA

This condition, formerly regarded as a rare hematological disorder, now appears to be increasing somewhat in frequency. We have treated nine cases with either cortisone or ACTH and all have exhibited definite evidence of worthwhile improvement. One patient who had been ill for two years with such an anemia, severe enough to require blood transfusions, was treated for two weeks with ACTH, 25 milligrams every six hours, and the medication was then stopped. She developed a complete and prompt remission and remains perfectly well without additional treatment after a period of two years' observation. All of the remaining patients relapsed shortly after medication was stopped, necessitating a second course of treatment which again controlled the anemia, and permitted splenectomy under safer conditions. This form of medical treatment, therefore, at least reduces the hazard of splenectomy in such patients and occasionally produces a prolonged remission and possibly a complete cure. In addition, the use of these therapeutic agents may control the abnormal destruction of transfused red blood cells by hemolysis, which sometimes occurs in patients with this form of hemolytic anemia.

LEUKEMIA

In my opinion, neither ACTH nor cortisone has a place in the treatment of *chronic leukemia* except in patients with multiple myeloma which is now generally considered to be subleukemic

plasmocytic leukemia, and in patients with chronic leukemia who have an acute exacerbation of the disease. In cases of *subacute and acute leukemia*, either in adults or children, however, such medication may serve a useful purpose.

In about 10 per cent of the adults, and a much higher proportion of children, often considerable and sometimes dramatic transient improvement is attained. For example, one of our patients, a male, 25 years of age, with acute granulocytic leukemia, was treated with 100 milligrams daily of ACTH for 10 days. The white blood cell count dropped from 300,000 per cubic millimeter, of which practically all were blasts, to 4,000 per cubic millimeter, with a complete disappearance of immature cells from the circulating blood, and a return of the bone marrow to normal. His spleen, which had been considerably enlarged, was no longer palpable, and he had an apparent complete restoration to health without the slightest evidence of leukemia which could be demonstrated by clinical means. After a period of five weeks he suffered a severe relapse. Following the same medication, a second perfect remission was induced which persisted for about three weeks. Treatment during the third relapse did not result in improvement and the condition terminated fatally although the same medication was given.

In children the results are somewhat better as about one-third develop temporary remissions, and an additional group show clinical improvement although evidence of this in the blood or bone marrow is lacking. The possibility of using this form of therapy in all acute and subacute forms of leukemia should be considered, either alone or in conjunction with folic acid antagonists medication. In terminal cases of chronic leukemia it also deserves a trial as it gives some comfort to the patient.

MULTIPLE MYELOMA

In my opinion, the treatment of choice of multiple myeloma is the roentgen ray. Urethane in daily doses, beginning with 0.3 grams t.i.d.

and increasing gradually to tolerance or until a daily dosage of 3.0 grams daily is reached, may give some symptomatic relief. The nausea which the drug causes, however, has prevented its extensive use in my experience. Radioactive phosphorus (P^{32}) has been used but probably is not as satisfactory as roentgen irradiation. In general, I believe that the patient should first be treated with the roentgen ray and when this becomes ineffective then cortisone should be used. This should first be given in doses of 75 milligrams every six hours for a period of 10 to 14 days, and then discontinued or a maintenance dose of 75 milligrams daily may be given.

When cortisone is given for 10 to 14 days and then discontinued, the patient often obtains complete symptomatic relief within a few days after the beginning of treatment and this may continue for two or three months. A second course and sometimes multiple courses may produce similar remissions of equal duration, but eventually the patient will become refractory to further similar therapy. Additional evidence of the beneficial effect of this medication is to be found in the reduction in the plasma globulin which is usually higher than normal in the untreated patients, a fall in the non-protein nitrogen of the circulating blood, and a decrease in the immature plasmocytes present in the bone marrow. Although a maintenance dose of 75 milligrams daily may be tried with good results, it too will become ineffective eventually.

FELTY'S SYNDROME

As you know, Felty's syndrome is characterized by the manifestation of rheumatoid arthritis, splenomegaly, leukopenia, lymphadenopathy, loss of body weight and sometimes cutaneous pigmentation. In some instances the white blood cell count may be below 1,000 per cubic millimeter and the neutrophils less than 30 per cent. As cortisone and ACTH have a beneficial effect both on the arthritis and the changes in the blood, and as splenectomy appears to benefit some of these patients, it has been of interest to observe the results obtained

from the use of these drugs in this disorder. In four patients whom we have treated, it was noted that all had striking and immediate improvement in joint manifestations and an increase in the white blood cell count.

Although in all four patients so treated there was a prompt and gratifying improvement, this was purely transient as in all a complete relapse occurred immediately following the discontinuance of the medication. In our opinion, splenectomy produces a much more satisfactory response, and should be given consideration as a form of treatment in all patients in whom this syndrome is well established.

HODGKIN'S DISEASE

Our experience does not indicate that this disorder should be treated with ACTH or cortisone except in the end stages when the patient has become refractory to roentgen irradiation and nitrogen mustard therapy. When such a state does occur, however, then either ACTH or cortisone may be employed and worthwhile results may follow. For example, one patient of ours, a fifteen year old boy with Hodgkin's disease, after being benefited by both the roentgen ray and nitrogen mustard, was no longer able to tolerate either form of medication as both provoked severe and persistent vomiting. As a trial, he was given 200 milligrams of cortisone for 14 days and then given a maintenance dose of 75 milligrams daily. From the beginning of cortisone therapy he was placed on an 800 milligram low sodium diet. His appetite increased remarkably, he developed a mild euphoria, and subsequently was able to tolerate both roentgen ray and nitrogen mustard therapy. Although the enlarged lymph nodes did not recede, there was a gain in body weight of 42 pounds in six months. This medication added six months of satisfactory life to his existence, which permitted him almost normal activity. There appears to be a place, therefore, in the far advanced cases of Hodgkin's disease for the use of cortisone or ACTH therapy which may produce a temporary partial relief of symptoms.

QUESTION AND ANSWER PERIOD

Q. DR. STURGIS: Dr. Conley, discuss briefly the value of iron in the treatment of anemias and the most suitable preparations.

DR. CONLEY: Iron has a very limited use in the treatment of anemia. It is of tremendous value in the treatment of anemias which are due to iron deficiency. When anemias are caused by iron deficiency, iron is specifically effective in causing correction of the anemia. Iron deficiency in infants and young children may be the result of inadequate iron intake, as in infants who are receiving a diet which consists only of milk. In adults, however, iron is required in very small amounts except by individuals who are bleeding. The occurrence of iron deficiency in adults is virtually pathognomonic of blood loss. The administration of iron will correct the anemia. It obviously does not correct the cause of the hemorrhage, so that the treatment of the patient consists not only of administration of iron, but of locating and correcting, if possible, the bleeding lesion. The administration of simple iron salts is all that is required to produce a therapeutic effect. Ferrous sulphate, for example, is perfectly adequate in amounts of a gram or two per day. Some patients find that they are unable to tolerate this because of gastrointestinal disturbances, and then other iron containing compounds may be used, such as ferrous gluconate. There are certain proprietary preparations which are well tolerated. One which incorporates iron in a colloidal complex is particularly well tolerated. There is important reason not to combine iron with other hematinic agents. The administration of a therapeutic agent provides a final diagnostic test. If the patient responds to the agent, then you prove that he needed it. If you combine iron with folic acid, vitamin B₁₂, and whatnot, if response occurs you don't know to what the patient may have responded.

Q. Should splenectomy be done in leukemia, if so, when?

DR. STURGIS: There is one rare possible

indication for splenectomy in leukemia and that is the development of a secondary hypersplenism which in my opinion does occur occasionally. One may suspect this complication in a case of leukemia when the patient develops a slight icterus, the blood bilirubin is slightly or moderately elevated, repeated blood transfusions fail to maintain the red blood cell count as well as one would expect, and there is an elevated reticulocyte count. If the spleen were removed when such a condition is present, it might be easier to control the associated anemia and possibly the purpuric manifestations. I have never observed a patient with leukemia in whom I thought splenectomy was indicated, but others are more optimistic about the results of the operation.

Q. DR. STURGIS: Dr. Norwood, would you discuss briefly the diagnosis and prognosis of monocytic leukemia?

DR. NORWOOD: Monocytic leukemia must be considered first in light of the fact that approximately 90% of the cases are acute leukemias. It follows then, that the response to treatment will not be encouraging and that the life expectancy is short. The fact that monocytic leukemia is more frequently diagnosed at the present time than it has been in the past, probably depends a great deal on the fact that it is an acute leukemia and that the more acute the disease, the more immature the cell forms observed. The more immature the cell form, the greater the difficulty of classification, so that the ultimate diagnosis of type may represent mainly the opinion of the examiner. To establish the diagnosis, smears must show the cells recognizable as monocytic in type, and for this, the most important point is the characteristic folding and doubling-over of the large, rather coarsely granular nucleus. From the clinical standpoint, we have the picture of acute leukemia, usually with purpuric manifestations. Enlargement of the glands is not striking. Enlargement of the spleen is also not striking, in

fact it may be scarcely palpable. Of the distinctive clinical features, I think infiltration of the mucous membranes, particularly of the mouth and gums, is most suggestive. It is by no means absolutely diagnostic since we see the same infiltration in other conditions. However, we see it so much more frequently in monocytic leukemia, that if we have a patient presenting the purpuric syndrome and the leukemic blood picture with intense infiltration and hyperplasia of the gums, I would certainly think very much of monocytic leukemia as a possible diagnosis and would look for other diagnostic support. As to the treatment, unless ACTH or Cortisone will give a temporary remission, I think that monocytic leukemia offers a rather discouraging therapeutic outlook.

Q. DR. STURGIS: Dr. Cooley, discuss briefly the treatment of polycythemia rubra vera.

DR. COOLEY: The treatment of this disease centers around the control of the red blood cell and total blood volumes. As an initial step a series of phlebotomies may be done until the packed red blood cell volume reaches 50-55%. The symptoms of the disease will often be relieved by this procedure alone. In order to maintain the blood within a normal range radioactive phosphorus is the preferable agent. It is given in sizeable doses and is continued until the blood count reaches a normal level and it suffices as a rule to produce remissions lasting from one to two years. The course of the disease is typically prolonged and the average duration of life is about five years. As the disease continues through remissions and relapses complications frequently enter the picture. A certain number of patients die with acute leukemia and others succumb to cerebrovascular accidents. After the disease enters the second decade of survival chronic leukemia becomes a real threat and about ten per cent of all cases of polycythemia vera die with this condition. Some have attributed this to attempts to control the disease by radiation. However this seems unlikely since chronic myelogenous leukemia was a frequently

observed complication before radiation was used as a treatment agent.

Q. DR. STURGIS: Dr. Sacks, will you discuss briefly the indications for splenectomy?

DR. SACKS: There seems to be no doubt that the performance of splenectomy in congenital hemolytic jaundice alleviates most of the clinical symptomatology from this disease. Although the intrinsic defect in the red cell persists, anemia no longer becomes an important factor. In acquired hemolytic anemia, as Dr. Sturgis has pointed out, one occasionally will get a complete remission or even cure by medical means, particularly Cortisone or ACTH, but more often in acquired hemolytic anemia these agents are adjunctive therapy for splenectomy. Of course splenectomy here does not uniformly guarantee the excellent results seen in congenital hemolytic jaundice, but it is an important mode of therapy. In patients with idiopathic thrombocytopenic purpura, unless a sustained remission can be induced by Cortisone, splenectomy should be considered. Aside from these entities, the other reasons for splenectomy are somewhat controversial and would require longer discussion. For example, the place of splenectomy in Banti's syndrome could be discussed at some length if time permitted.

Q. What is the current status concerning the usefulness of TEM,—triethylene melamine?

DR. STURGIS: Triethylene melamine has two possible advantages, first it can be given orally, and it acts in a way similar to nitrogen mustard in Hodgkin's disease. Second, it is also effective in the treatment of the acute and subacute leukemias. It has one serious objection in my opinion, and this is that the toxic dose is close to the therapeutic dosage. A slight overdose may result in aplasia of the bone marrow. Especially to be feared is a serious reduction in the blood platelets and the neutrophils of the circulating blood. Although others assume a more liberal attitude toward the use of this drug, I consider that the possible harm it may do outweighs the benefits it may possess.

Q. What are the indications for splenectomy in Gaucher's disease?

DR. STURGIS: I think two. One, the spleen may become so huge that it should be removed for mechanical reasons alone. Second, splenectomy is indicated if there is evidence of hypersplenism as shown by the enlarged spleen, the hyperplastic bone marrow, and a reduction in

the red blood cells, the neutrophils or the platelets, or all three in the circulating blood. In the few cases I have observed, in which a splenectomy was done, the results were good.

DR. STURGIS: Now, if we have nothing further, I think we will thank you for your very kind attention to this rather prolonged program and call it adjourned. Thank you.

(APPLAUSE)

EXAMINATION ANNOUNCED FOR MEDICAL OFFICER

The United States Civil Service Commission wishes to bring to your attention the new Medical Officer examination for filling the positions of rotating intern, \$2,800 a year, and resident in training in psychiatry and in neurology, \$3,400 to \$4,200, in St. Elizabeths Hospital in Washington, D. C.

For intern positions, applicants must be fourth-year students in an approved medical school. To qualify for the resident positions (psychiatry and neurology) applicants must be graduates of an approved medical school with the degree of doctor of medicine and must have successfully completed a year's internship, or now be serving such internship. No written test is required. The maximum age limit (waived for persons entitled to veteran preference) is 35 years.

Applications will be accepted by the Executive Secretary, Board of U. S. Civil Service Examiners, St. Elizabeths Hospital, Washington 20, D. C., until further notice, but qualified persons are urged to apply at once.

UNITED STATES CIVIL SERVICE COMMISSION

Component Medical Societies

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

The December meeting has just been held. It was truly the "president's" meeting. The stimulating panel on tuberculosis was probably the best in the series of panel programs inaugurated by President Fort. The attendance, two hundred and fifty plus, is a tribute to his leadership and understanding of what the members want.

The motion by Doctor Needle that each past-president, beginning with President Fort, be presented a key or other emblem in recognition of service was timely and appropriate. President-elect Gundry has a high mark to shoot at indeed.

The Postgraduate Courses Committee has its program in your hands. By the time its program goes to print one or more of the courses will have been finished, and the big question, whether the lecture halls will be adequate, will be answered.

Whether another closed-circuit telecast can be arranged is uncertain. The sponsors "...are convinced this type of program has very excellent possibilities for future development; in fact, we would be happy to consider having a part in future undertakings of this character.

"However the receipt of letters...assists our efforts to obtain appropriations necessary for such purposes, and we are quite hopeful that more will come in...."

The following officers, etc. were elected to serve for 1954 unless otherwise indicated:

President, L. P. Gundry; *First Vice-President*, A. R. Koontz; *Second Vice-President*, G. E. Ward; *Secretary*, E. F. Cotter; *Treasurer*, R. C. Kimberly; *Councilors*, L. L. Keown (1954), R. E. Lenhard (1954), Wetherbee Fort (1954), Samuel Wolman (1954-1955), H. E. Wilgis (1954-1955), D. J. Pessagno (1954-1955); *Delegates* (1954-1955), P. Artigiani, S. T. R. Revell, Jr., M. S. Sacks, J. W. Barnaby, Jr., F. W. Gluck, J. N. Classen, Gustav Highstein, J. C. Handelsman, M. P. Johnson,

Charlotte McCarthy, S. E. Muller, L. H. Pierce, F. K. Morris; *Alternate Delegates* (1954-1955), K. V. Kemp, M. L. Singewald, R. C. Abrams, P. C. Phelan, Jr., H. P. Biehl, E. H. Richardson, Jr., W. A. Anderson, V. C. Kelly, R. A. Reiter, J. D. Moores, J. F. Supplee III, K. K. Krulevitz, Abraham Genecin.

CAROLINE COUNTY MEDICAL SOCIETY

ROBERT H. WRIGHT, M.D.

Journal Representative

A meeting of the Caroline County Medical Society was held at the Tidewater Inn, Easton, December 19, 1953. Preparation was discussed for the January Meeting of the Upper Eastern Shore Medical Society, Brick Hotel, Denton.

The following were elected officers for the year 1954: *President*, H. Fletcher Silver, Goldsboro; *Vice-President*, Robert H. Wright, Greensboro; *Secretary-Treasurer*, Edwin G. Riley, Denton; *Delegate*, Charles H. Winnacott, Ridgely; *Alternate*, Harold B. Plummer, Preston and *Journal Representative*, Robert H. Wright, Greensboro.

CHARLES COUNTY MEDICAL SOCIETY

J. PARRAN JARBOE, M.D.

Secretary

At the meeting of the Charles County Medical Society the following officers were elected:

President, Richard F. Daly, La Plata; *Vice-President*, Harry R. Coburn, Bryantown; *Secretary-Treasurer*, J. Parran Jarboe, La Plata; *Delegate*, Arthur O. Wooddy, La Plata; *Alternate*, John H. Griffin, Hughesville; *Chief of Staff Physicians Memorial Hospital*, Edward J. Edelen. The officers were installed on Thursday, December 17, at the Hawthorne Country Club.

Meetings are held at the Jarwood Clinic in La Plata, Maryland on the second Thursday of every month at 8:30 p.m.

FREDERICK COUNTY MEDICAL SOCIETY

JESSE S. FIFER, M.D.

Journal Representative

The Frederick County Medical Society is an active one, in that it meets once a month except for July and August. Each meeting is preceded with cocktails and a dinner, followed by a business and scientific program. Meetings are well attended with an average of about three fifths of the membership. The following is our 1954 program:

January—Dr. John Whitridge—"Present Day Aspects of Toxemias of Pregnancy"

February—Dr. Lawson Wilkins—"Facts and Fallacies of Endocrinology"

March—Dr. Robert Furie—"Fluid Balance"

April—Dr. Francis A. Ellis—"Diagnosis and Treatment of Common Dermatoses"

May—Dr. R. K. Thompson—"Pain of the Head and Neck"

June—Dr. Charles Wainwright—"Arthritis"

September—Dr. Helen B. Taussig—"Selection of Patients for Surgery with Congenital Heart Condition"

October—Dr. Edwin H. Stewart, Jr.—"Tumors of the Head and Neck"

November—Annual Election of Officers and Business Meeting

December—Dr. Leonard Scherlis—"Recognition and Management of Cardiac Arrhythmia"

The following physicians have started practice in the County during 1953:

Bernard M. Davis, Jr.—General Practice—Frederick

Charles R. Williams—General Practice—Emmitsburg

Albert M. Powell, Jr.—Pediatrics—Frederick

Joseph Lerner—Neuro-psychiatry—Ijamsville

Henry Chase—General Practice—Frederick—Returned to practice November 4th.

We have lost two physicians, both moved to places in the west, who are:

Dr. William W. Orrison—to Oklahoma, and Dr. Hosea MacAdoo—to Arkansas.

HARFORD COUNTY MEDICAL SOCIETY

ROBERT BARTHEL, M.D.

Journal Representative

Minutes of meeting December 3, 1953

The following members were present: Doctors Barthel, Finney, Foley, Hatem, Hayman, Hodous, Horky, Hudson, Marek, McDonald, Norment, Rodman, Stewart, Stonesifer, Wolbert. *Guests:* Drs. Brendle, J. Dolce, Heuman

1. Veterans Medical Care—The secretary was directed to write to our senators and congressmen opposing care for non-service connected disabilities. (Motion by Finney, second by Hudson, passed unanimously.)
2. Formation of executive board to replace the board of censors, with authority to act for the society. This board is to consist of the president, vice-president, secretary-treasurer, and delegate.
3. Formation of Woman's Auxiliary—This request from the state society was referred to the Executive Board.
4. Dues for 1954—The secretary-treasurer will continue to collect county and state dues, *but not AMA dues.*
5. Maryland adoption law—The society is to request a hearing by the state legislative committee. Dr. Horky's statement is to be transmitted by the secretary. (Motion by Horky, second by Wolbert, passed unanimously.)
6. Insurance forms—A committee to consider a simplified form is to be appointed by the president. (Motion by Horky, second by Hatem, unanimously passed.)

7. NEW MEMBERS:

Brendle and Heuman were accepted for full membership. (Motion by Horky, second by Rodman, unanimously passed.)

8. ELECTION OF OFFICERS:

President, Robert Barthel, Forest Hill; *Vice-President*, Charles J. Foley, Havre de Grace; *Secretary-Treasurer*, Charles R. Hayman, Bel-Air; *Delegate*, Peter P. Rodman, Aberdeen; and *Alternate*, Richard Norment, III, Havre de Grace.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

J. M. WARREN, M.D.

Journal Representative

Our annual election meeting was held December 1, and the following are our officers for the calendar year 1954: Dr. Julius Kauffman, 5102 Annapolis Road, Bladensburg, *President*; Dr. Benjamin Miller, 3824 34th Street, Mt. Rainier, *Vice-President*; Dr. William B. Hagan, 3303 Perry Street, Mt. Rainier, *Recording Secretary*; Dr. John S. Haught, 3303 Perry Street, Mt. Rainier, *Corresponding Secretary*; Dr. Albert Roth, 5507 Madison Street, Riverdale,

Treasurer. *Delegates* chosen to the Medical and Chirurgical Faculty were Dr. John Warren, 305 Prince George Street, Laurel, and Dr. Waldo B. Moyers, 3503 Perry Street, Mt. Rainier. *Alternate Delegates* selected were Dr. Samuel Sugar, 4300 Kaywood Drive, Mt. Rainier, and Dr. Wolcott Etienne, 4713 Berwyn Road, College Park. Dr. John T. Maloney, 2202 Cheverly Avenue, Cheverly, was selected to fill the one unexpired term of *Censor*.

The only other news forthcoming from this meeting was the report on our Annual Diabetes Detection Drive under the chairmanship of Dr. Samuel J. N. Sugar. Dr. Sugar reported a total of 1,521 tests had been performed from which 91 positive results had been recorded.

MILITARY PROMOTION REGULATIONS CHANGED

The AMA Washington Letter—No. 47

Some medical reserves will benefit from a change in Defense Department's directive on the revised doctor draft act. Under the first directive issued October 7, only experience prior to acceptance of a commission counted in determining whether the officer was entitled to a higher rank under the new law. The effect of the change is to credit all experience up to the time the officer goes on active duty. Under the previous interpretation, a number of men were in effect penalized in grade for the two or three years spent in the reserves prior to going on active duty. The new regulation means higher grades for some men when they are called up and promotions for others already on active duty.

MISCELLANY

The AMA Washington Letter, No. 50

Kenneth Williamson is taking over as the new director of the Washington Service Office of the American Hospital Association, succeeding Albert V. (Burt) Whitehall, who becomes executive director of the Washington (state) Hospital Service, with headquarters in Seattle. Mr. Williamson was assistant director of AHA for seven years before becoming executive vice president of Health Information Foundation. . . The new seal of AMA will be used in a Hill-Burton display to be shown starting in January in the Department of Health, Education and Welfare Building . . . Department of Health, Education, and Welfare reports 2,825 persons engaged as medical social workers in the United States, but says there are three jobs in this field for every qualified person.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

JAUNDICE AND DISEASES OF THE LIVER

LOUIS KRAUSE, M.D.

"For the king of Babylon stood at the parting of the way, at the head of the two ways, to use divination; he made his arrows bright, he consulted with images, he looked into the liver."—Ezekiel 21:21.

This verse refers to the ancient custom of basing the prognosis on inspecting the liver of a recently killed animal. Again, another instance of the importance of the liver we find constantly in our frequent use of the word, *melancholy*. This word originally came from the Greek meaning black bile, and was thought to be the cause of the feeling of depression. Here they thought the black bile came to the liver from the spleen since the average person at that time had an easily palpable spleen because of the presence of malaria, in all likelihood; and one could understand that they would feel a little on the depressed side with the presence of a chronic malaria.

It is obvious that they placed a great deal of importance on the liver even in ancient days, and rightly so. Today, we have, in spite of the 500 or more functions that have been documented for the liver, many unrecognized and unexplained functions and mechanisms. Without a doubt it is one of the most vital and most adaptive organs, and possesses the unusual ability of regenerating itself; this in such contrast to many other vital organs of the body. This fact is being recognized more and more today, and with every new advance in investigative technique, additional function and capacity of the liver are revealed.

The appended list of books broadly surveys the earliest and much of the latest information pertaining to the liver in health and in disease. The books are all available in the library.

BOOKS ON JAUNDICE

Bickel, A. Experimentelle Untersuchungen ueber die Pathogenese der Cholaemie. Wiesbaden, Bergmann, 1900.

Brule, M. Recherches sur les ictères. 3d ed., Paris, Masson, 1922.

Harley, G. Jaundice: its pathology and treatment. London, Walton and Maberly, 1863.

James, P. Dissertatio medica inauguralis, de ictero. Edinburgh, Balfour, 1787.

Legg, J. W. On the bile, jaundice and bilious diseases. New York, Appleton, 1880.

Lloyd, T. W. On the aetiology of acholuric family jaundice. Smethwick, B. T. Hill, Soho, 1940.

Norcom, J. An inaugural thesis on jaundice; containing observations on the liver and some of its diseases. Philadelphia, Carey, 1799.

Ravenscroft, J. Disputatio medica inauguralis de ictero. Edinburgh, Balfour, Auld, and Smellie, 1770.

Sermon, W. A friend to the sick: or, the honest English mans preservation. London, Edward Thomas, 1673.

Walters, W. Obstructive jaundice: physiologic and surgical aspects. Owatonna, Minnesota Journal-Chronicle, n.d.

BOOKS ON DISEASES OF THE LIVER

Acard, E.-A. Contribution à l'étude des cirrhoses pigmentaires. Paris, Steinheil, 1895. Thèse.

Annesley, J. Sketches of the most prevalent diseases of India. London, Highley, 1831.

Bassler, A. Diseases of the intestines including the liver, gall-bladder, pancreas and lower alimentary tract. 3d ed., Philadelphia, Davis, 1928.

Bellamy, T. Noctes Sarniae; de jecinoris morbis, vel tractatio simul morbidis urinae signis, authoré. Sarnia, G. Hamiltoni, 1850.

Boix, E. The liver of dyspeptics. New York, Putnam, 1897.

Boyce, F. F. The role of the liver in surgery. Springfield, Ill., Thomas, 1941.

Budd, G. On diseases of the liver. Philadelphia, Lea & Blanchard, 1846; also 2d American ed., 1853.

Cavina, C. Le indicazioni ed i metodi della resezione epatica. Bologna, Cappelli, 1952.

Cope, Z. Surgical aspects of dysentery including liver abscess. London, H. Frowde, 1920.

- Crawford, J. An essay on the nature, cause and cure of a disease incident to the liver. London, G. Kearsley, 1772.
- Cyr, J. *Traité de l'affection calculuse du foie*. Paris, V. Delahaye, 1884.
- Drysdale, T. *Tentamen medicum inaugurale varia de hepate proferens*. Philadelphia, Dobson, 1794.
- Faithhorn, J. Facts and observations on liver complaints, and bilious disorders in general. 1st American ed., Philadelphia, Hickman, 1820; also 2nd American ed., 1822.
- Frerichs, F. T. *Atlas of pathological anatomy illustrative of a clinical treatise on diseases of the liver*. 2d corrected ed., Brunswick, Frederick Vieweg, 1862. 2 vols.
- Frerichs, F. T. *A clinical treatise on diseases of the liver*. London, The New Sydenham society, 1860-1861. 2 vols.
- Frerichs, F. T. von. *Pathologisch-anatomischer Atlas zur Klinik der Leberkrankheiten*. 2d enl. ed., Braunschweig, Vieweg, 1861.
- Genner, V. *By-effects in salvarsan therapy and their prevention*. Copenhagen, Levin & Munksgaard, 1936.
- Graham, E. A. and others. *Diseases of the gall-bladder and bile ducts*. Philadelphia, Lea, 1928.
- Habershon, S. O. *The Lettsomian lectures delivered at the medical society of London, 1872, on the pathology and treatment of some diseases of the liver*. London, Churchill, 1872.
- Hale-White, Sir W. *Common affections of the liver*. London, J. Nisbet, 1908.
- Hanot, V. *La cirrhose hypertrophique avec ictère chronique*. Paris, Rueff, 1892.
- Harley, G. *The diseases of the liver*. Philadelphia, Blakiston, 1883.
- Harrower, H. R. *The hepatic principle, anabolin, detoxication by the liver and the control of functional hypertension*. London, Baillière, 1927.
- Heyd, C. G. & others. *The liver and its relation to chronic abdominal infection*. St. Louis, Mosby, 1924.
- Johnson, J. *A treatise on derangements of the liver, internal organs and nervous system*. Philadelphia, Carey and Lea, 1825; also 1826.
- Kiernan, F. *The anatomy and physiology of the liver*. London, R. Taylor, 1833.
- Knox, R. *Radiography in the examination of the liver, gall-bladder and bile ducts*. St. Louis, Mosby, 1920.
- Körte, W. *Beiträge zur Chirurgie der Gallenwege und der Leber*. Berlin, Hirschwald, 1905.
- Lancereau, E. *Traité des maladies du foie et du pancréas*. Paris, Doin, 1899.
- Leblond, V. *Diagnostic et traitement des abcès du foie*. Paris, Baillière, 1893.
- Lereboullet, P. *Les cirrhoses biliaires*. Paris, Masson, 1902.
- Lichtman, S. S. *Diseases of the liver, gall-bladder, and bile ducts*. 2d ed., Philadelphia, Lea & Febiger, 1949.
- MacCallum, F. O. *Infective hepatitis; studies in East Anglia during the period 1943-47*. London, H. M. Stationery Off., 1951.
- McCausland, R. *Dissertatio medica, inauguralis, de hepatide. pro gradu doctoris*. Edinburgh, Balfour, 1787.
- Malcolmson, J. G. *Clinical remarks on some cases of liver abscess*. Philadelphia, Haswell, Barrington, and Haswell, 1839.
- Mathews, S. *Observations on hepatic diseases, incidental to Europeans in the East-Indies*. London, Cadell, 1783.
- Merck and Company. *Choline and methionine in the treatment of liver diseases*. Rahway, N. J., Merck, 1946.
- Mukherji, S. K. *Infantile cirrhosis of liver*. Calcutta, Indian Medical Record Book Department, 1922.
- Murchison, C. *On functional derangements of the liver*. New York, William Wood, 1875; also 1879.
- Portal, A. *Observations sur la nature et traitement des maladies du foie*. Paris, Longchamps, 1813.
- Quincke, H. *Die Krankheiten der Leber*. 2. Auflage. Wien und Leipzig, Hölder, 1912.
- Rolleston, Sir H. D., bart., and McNee, J. W. *Diseases of the liver, gall-bladder and bile ducts*. 3d ed. London, Macmillan, 1929.
- Roose, R. *Gout; its relations to diseases of the liver and kidneys*. London, Lewis, 1894.
- Saunders, W. *A treatise on the structure, economy and diseases of the liver*. Boston, Pelham, 1797; also London, W. Phillips, 1803.
- Schwartz, E. *Chirurgie du foie*. Paris, Doin, 1901.
- Stock, T. *Disputatio medica inauguralis de hepatide*. Edinburgh, Neill, 1802.
- Stone, A. D. *A practical treatise on the diseases of*

the stomach and of the digestion; including the history and treatment of those affections of the liver and digestive organs. London, Cadell and Davies, 1806.

Thomson, W. A practical treatise on diseases of the liver. Philadelphia, Barrington and Haswell, 1842.

Waterlow, J. C. Fatty liver disease in infants in the British West Indies. London, H. M. Stationery Office, 1948.

Weiss, S. Diseases of the liver, gall-bladder, ducts and pancreas; their diagnosis and treatment. New York, Hoeber, 1935.

REED INDICATES PHYSICIANS WILL BE EXCLUDED FROM OASI BILL

The AMA Washington Letter, No. 50

Chairman Daniel A. Reed (R., N. Y.) of the House Ways and Means Committee has indicated that in his opinion Congress should not force mandatory social security coverage on physicians and others who don't want it. Mr. Reed's committee will hold public hearings after the first of the year on the administration's proposal to extend Old Age and Survivors Insurance to about 10,500,000 more persons. The administration bill, introduced last August, would mandatorily take in physicians, dentists, farmers and virtually all other groups of self-employed.

In a statement outlining the committee's plans, however, Mr. Reed made clear that he is not in favor of compulsory coverage for groups that oppose coverage. He declared: "I believe that social security coverage should be extended to any group *which desires it.*" At its meeting earlier this month in St. Louis, the AMA's House of Delegates reaffirmed that the country's physicians *do not desire* social security.

Other committee objectives, as stated by Mr. Reed: Liberalize the present \$75 per month limit on earnings of OASI recipients, raise the level of minimum benefits and allow the social security tax to go up one half per cent as scheduled on January 1. Mr. Reed said that in the hearings "every interested group will be given an opportunity to testify."

DR. WILBUR ON MEDICAL TASK FORCE

The AMA Washington Letter—No. 47

Dr. Dwight L. Wilbur of San Francisco, clinical professor of medicine at Stanford University medical school, is the newest appointment to the medical task force of the Hoover Commission. A commission spokesman said his acceptance was received after release of the names of the remaining members last week. Dr. Wilbur is prominent in activities of the American Medical Association and his state medical society. He served in the Navy in World War II and has taken part in state and community civic work. Due to an error in biographical material furnished by the commission, Dr. Francis J. Braceland, a task force member, last week was incorrectly identified as dean of Loyola (Chicago) University School of Medicine. A former dean of Loyola, he is now full-time psychiatrist at the Institute of Living, Hartford, Connecticut.

Health Departments

HOME ACCIDENT PREVENTION STUDY

R. H. RILEY, M.D., Dr.P.H.*

Baltimore, Md.

During 1953 the Maryland State Department of Health has been preparing for the inauguration of a Home Accident Prevention program throughout the State. The planning stage is now completed and an epidemiological study of fatal home accidents was begun on January 1, 1954.

All physicians are aware of the remarkable achievements of preventive medicine during the past several decades. The application of its principles to communicable disease for example, has brought about an unbelievable improvement in mortality. Now that many of the infectious diseases have been brought under control, the present-day physician is brought face to face with the fact that in Maryland accidents are now the fourth leading cause of death and home accidents account for approximately one-third of this group. With these facts in mind, the plan as outlined by the State Health Department was approved by the House of Delegates of the Medical and Chirurgical Faculty on April 23, 1953.

This program was made possible by a financial grant to the State Health Department from the W. K. Kellogg Foundation of Battle Creek, Michigan. This Foundation in its desire to promote the health and education of mankind and to generally improve the level of living has made this grant available for a three year period to eight States, including Maryland.

Every effort is being made to cooperate with other organizations having an interest in this problem, such as the American Academy of Pediatrics accident prevention committee, American Red Cross, the Baltimore Safety Council, State Industrial Accident Commission, civic organizations, local youth organizations and 4H clubs as well as the local press, radio and television stations.

The procedure for obtaining the necessary infor-

mation required for this study will follow a prescribed pattern. A "Home Accident Fatality Report" partially reproduced in Figure 1, will be used by the local Health Department personnel in reporting information obtained from the interview with the informant.

As death certificates are received in the Division of Vital Records and Statistics of the Maryland State Health Department, they are processed and classified. Those certificates indicating an accidental death and not subject to normal investigation by local or State police departments, the Bureau of Motor Vehicles, the Industrial Accident Commission, the CAA or aviation commission, will be selected for investigation by the local Health Department.

The information on the Death Certificate will be transposed to the top portion of the "Home Accident Fatality Report." This form will be sent to the Bureau of Environmental Hygiene for review by the Home Accident Prevention unit in order to eliminate any inquiries which seem unjustifiable. The form would then be sent to the proper counties by the Bureau of Environmental Hygiene for completion.

In reviewing the information on the death certificate or top portion of this form, the County Health Officer will decide which person on his staff—public health nurse, sanitarian, or social worker—will be assigned the investigation. Where death was the result of a farm accident, a public non-motor-vehicle accident or home accident involving appliances or machinery, the sanitarian may be the best qualified person to make the investigation. The public health nurse would probably be asked to investigate most other home accidents. In the few counties having a social worker, he or she might be asked to do the investigation, particularly when that person has previously worked with the family and has established a good relationship with them.

In accordance with the agreement with the Medical and Chirurgical Faculty, each of these cases will be discussed with the family physician prior to calling on the home of the deceased person. It is quite possible that the family physician can pave

* Director—Maryland State Department of Health.

HOME ACCIDENT FATALITY REPORT
(Excerpt of Information to be Obtained by Interview)

INFORMANT: Please answer questions below.

6. What was the deceased doing when accident occurred?
7. a. Was an object involved in the accident? ☐ NO ☐ YES If YES, name the object.....
(For example, table, gun, stairs)
- b. If YES, was the object (check one) ☐ Worn ☐ New ☐ Defective ☐ In good condition ☐ Other (Explain).....
8. a. Was an agent such as fire, gas, water, poison, etc., involved in the accident? ☐ NO ☐ YES If YES, name the agent.....
- b. If fire was involved where did it start? What caused it?
- c. If fire was caused by heating equipment (for example, stove or furnace) what kind of fuel was being used?
- d. If poison was involved, what kind was it? (For example, cooking gas, rat poison, barbiturate, kerosene).....
- e. If poison was swallowed, where did the deceased find it? (For example, in medicine chest, on shelf in kitchen).....
9. Did poor lighting figure in this accident? ☐ NO ☐ YES ☐ DON'T KNOW
10. a. Was the deceased physically handicapped before this accident? ☐ NO ☐ YES ☐ DON'T KNOW
- b. If YES, what was the handicap? Did it lead to the accident? ☐ NO ☐ YES (Explain).....
11. Did another person's action figure in the accident? ☐ NO ☐ DON'T KNOW ☐ YES (Explain).....
12. Where in the home or outside of it did the accident occur? (For example, bedroom, hall, yard)
13. Was an adult with the deceased when the accident took place? ☐ NO ☐ YES ☐ DON'T KNOW
14. How many others were injured or killed in this accident? ... Injured ... Killed
15. In your opinion how could this accident have been prevented?
16. Did the deceased receive medical attention? ☐ NO ☐ YES If YES, how soon after the accident? ... Hours ... Days
17. Within 12 months before this accident, was deceased in any other accident which required medical attention, absence from work, or staying in bed? ☐ NO ☐ YES If YES, how many other accidents? ... DON'T KNOW
18. a. Was the deceased the head of the family? ☐ NO ☐ YES b. Number of survivors who were dependent on the deceased's income.....
19. Describe in a few words how this accident took place.....

DATE	NAME OF PERSON COMPLETING THIS REPORT	RELATIONSHIP TO DECEASED (OR TITLE)
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ORIGINAL—STATE BUREAU OF VITAL STATISTICS

FIGURE 1

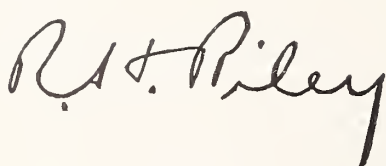
the way for the visit or be able to give much of the information required on the report form. If the name of the attending physician cannot be ascertained until after a contact is made with the family, the physician will be furnished with a report of the visit.

In addition to the family physician, the County Medical Examiner and local and State police departments may have information which will be of value to the Health Department in this investigation. Such data will serve to supplement the information supplied by the family and will be used if it has value to the study.

Inasmuch as the requests for investigation will be relatively few in each county, it is hoped that visits can be made within a few days after the report form is received. There are two very good reasons for not delaying the investigation: first, the account of the accident will be more accurate if the investigation is completed before certain facts become hazy or partially forgotten and, second, an interview when the family is already emotionally disturbed may create comparatively little additional disturbance while an interview at a later date, when the family has made certain emotional adjustments, may re-activate their grief and their feeling of responsibility. Here again the timing of the approach will be discussed with the family physician.

When the investigation has been completed by the County Health Department, the report form will be returned to the Home Accident Prevention unit of the Bureau of Environmental Hygiene for study and interpretation and will then be turned over to the Division of Vital Records and Statistics for tabulation.

The project which will consist of a comprehensive study and analysis of the underlying causes of all fatal home accidents as well as a limited epidemiological study of non-fatal home accidents will provide the necessary information for a preventive action program. It is intended that by pinpointing the problem and following through with an appealing educational program that many of these "needless" accidents can and will be prevented in the local communities of the State.



Director

BALTIMORE CITY HEALTH DEPARTMENT

Neonatal Home Nurse Visiting Program Modified

On December 10, 1953 the City Health Department wrote to each of the seventeen hospitals having maternity hospital licenses under the city ordinance advising them of changes in the Health Department public health nurse home visiting program for newborn babies. After careful study it was decided to limit the visiting to those mothers who would stand to benefit the most from such public health nursing visits. The new program became effective on January 1, 1954. The text of the letter sent on December 10 to chief obstetricians and chief pediatricians at each of the 17 hospitals, and to the hospital directors is as follows:

Dear Doctor:

At present, the resident mother of every infant born alive in this City is visited by a public health nurse approximately two weeks after birth of her child. With the passage of time and in view of our desire to conserve valuable nursing skills, we have found it necessary to study carefully the merits of visiting every mother regardless of need. Our impressions are that large segments of the white mother population make early provision for routine care of the newborn baby, and that the chief causes of death, premature birth, birth injury and congenital malformation, are conditions whose prevention, if any, lies in the prenatal period.

On the other hand, the mortality among Baltimore's colored infants, 40 deaths per 1,000 born alive, is about twice the rate for white babies. Analysis of this excess mortality indicates that death rates from preventable causes, i.e., pneumonia, malnutrition and accidental causes are higher among Negro infants than among the white infants. This excess is believed due to inadequate care in the home, to ignorance or to irresponsibility.

With these considerations in mind, we propose to modify our neonatal home visiting program as follows:

All babies in the following categories will be visited at home as soon as possible after birth:

1. Premature infants (below 2500 grams in birthweight).
2. Infants injured at birth.
3. Infants malformed at birth.
4. Negro infants.
5. Infants delivered at home.
6. Other babies at the discretion of the district health officer or the district supervising nurse or upon request of the attending physician at the hospital of delivery. Such requests should be made by telephone or mail to the Bureau of Public Health Nursing, Plaza 2-2000, Extension 404.

It is planned to introduce the new program on January 1, 1954. If you have any suggestions in regard to the above, we would welcome them. Please feel free to communicate with Dr. Janet Hardy, our Director of the Bureau of Child Hygiene, who will be glad to discuss them with you, Plaza 2-2000, Extension 324.

Sincerely yours,

Huntington Williams, M.D.

Commissioner of Health

FOUR GROUPS AT WORK WITHIN HOOVER COMMISSION MEDICAL TASK FORCE

The AMA Washington Letter, No. 51

To facilitate the gathering of information from government agencies and other sources, the Hoover Commission Medical Task Force has separated itself into four divisions. The findings will be "considered fully by the whole Task Force," according to the commission, before any conclusions are reached or any recommendations made. The makeup of the four teams:

Medical Services of the Armed Forces—Drs. E. D. Churchill (chairman), Michael DeBakey (co-chairman), Walter Martin, president-elect of the AMA, and Dwight L. Wilbur. Medical Services of the Veterans Administration—Drs. Basil C. MacLean (chairman), Francis J. Braceland, Evarts A. Graham, and Otto W. Brandhorst. Medical Services of the U. S. Public Health Service and Other Federal Services—Drs. Theodore Klumpp (chairman), Hugh Leavell (vice chairman), and Milton C. Winternitz. Overall Planning for Medical Services in Time of War—Drs. Paul Hawley (chairman), Alan Gregg (co-chairman) and James Roscoe Miller.

The commission also announced that Dr. James P. Dixon, formerly Philadelphia health officer and formerly acting director of the Clinical Center at Bethesda, Md., will be secretary of the Task Force and an assistant to Dr. Edwin L. Crosby, the research director.

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT
Case Reports Received during 4-week Period, January 1-January 28, 1954

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARA- LYTIC	POLIOMYELITIS, NON PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County.....	114	—	4	7	99	—	82	—	—	—	21	1	—	13	5	1	6	—	3
Anne Arundel.....	22	—	—	5	2	—	9	—	—	—	5	1	—	1	3	—	6	t-1	2
Howard.....	1	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Harford.....	19	—	1	17	3	—	55	—	—	—	10	—	—	5	2	—	—	—	1
Carroll.....	4	—	—	1	21	—	5	—	—	—	2	—	—	—	—	—	—	—	—
Frederick.....	9	—	—	3	2	—	1	—	—	—	12	—	—	1	2	—	1	—	2
Washington.....	3	—	—	10	1	—	10	—	—	—	9	—	—	—	4	—	1	—	1
Allegany.....	2	—	—	3	1	—	—	—	—	—	—	—	—	—	1	—	1	—	3
Garrett.....	—	—	—	2	1	—	—	—	—	—	—	—	—	—	1	—	1	—	—
Montgomery.....	27	—	1	1	2	—	36	—	—	—	8	—	—	—	10	—	1	—	2
Prince George's.....	13	—	—	1	1	—	3	—	—	—	4	—	—	1	5	—	1	—	5
Calvert.....	1	—	—	2	—	—	—	—	—	—	—	—	—	9	2	—	—	—	1
Charles.....	3	—	—	3	—	—	4	—	—	—	—	—	—	—	—	—	—	—	1
Saint Mary's.....	6	—	—	19	—	—	2	—	—	—	3	—	—	—	2	1	4	—	1
Cecil.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Kent.....	1	—	—	3	—	—	11	—	—	—	6	—	—	4	—	1	—	—	—
Queen Anne's.....	1	—	—	—	—	—	3	—	—	—	—	—	—	—	1	—	—	—	2
Caroline.....	1	—	—	—	6	—	1	—	—	—	—	—	—	1	2	—	2	t-1	1
Talbot.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—
Dorchester.....	1	—	—	—	1	—	—	—	—	—	—	—	—	—	4	—	8	—	—
Wicomico.....	7	—	4	—	52	1	—	—	—	—	1	—	—	—	5	1	11	t-2	—
Worcester.....	—	—	—	5	22	—	3	—	—	—	—	—	—	1	1	—	—	—	1
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	3	—	—
Total Counties.....	235	0	10	84	214	1	225	0	0	0	81	2	0	36	52	4	47		27
Baltimore City.....	379	0	6	3	477	3	146	1	0	0	38	0	0	53	64	14	592	—	34
State																			
Jan. 1-28, 1954.....	614	0	16	87	691	4	371	1	0	0	119	2	0	89	116	18	639		61
Same period 1953.....	553	1	49	36	78	8	108	1	0	0	211	0	1	23	241	12	687		86
5-year median.....	375	6	27	—	540	7	114	2		0	129	1	4	52	181	25	540		60
Cumulative totals																			
State																			
Year 1954 to date.....	614	0	16	87	691	4	371	1	0	0	119	2	0	89	116	18	639		61
Same period 1953.....	553	1	49	36	78	8	108	1	0	0	211	0	1	23	241	12	687		86
5-year median.....	375	6	27	—	540	7	114	2		0	129	1	4	52	181	25	540		60

t = tularemia.



Blue Cross - Blue Shield



SUBSCRIBER SERVICE

R. H. DABNEY*

Saratoga 7-6313 is a direct line to service. Through its trunks and its extensions, our subscribers voice their problems, their questions and, not infrequently, their opinions. Few telephone numbers mean as much to so many people, and none is any more sensitive or any more responsive to the human traffic moving back and forth over its circuits.

Subscribers under Blue Cross and Blue Shield not only receive service benefits, but just as important, the benefits of service. To listen to their voices is to grasp the full meaning of this distinction. A young housewife calling long-distance from Hagerstown asks to include her new-born child under a family membership. On another extension, a steelworker employed at a local shipyard requests a transfer from Pittsburgh to Baltimore. Sometimes at the rate of 5,000 calls a day, they ask—and they receive.

The volume is great. Year after year, as enrollment swings upward, the people who know the answers (our employees) do more and more for the people who ask the questions (our subscribers). Although too high a utilization rate in hospital-medical-surgical benefits could virtually cripple Blue Cross and Blue Shield, the incidence rate in service is never an abuse.

For us, service is not just a catchword, or a fancy sales slogan. Helping our subscribers—The Blue Cross and the Blue Shield public—is actually our job. Through our help, our subscribers always learn something more about their membership and, in learning, benefit themselves by a more effective use of the program. If, in our public relations for the program, we talk most about service benefits, it is not because we neglect, in our human relations with subscribers, to provide for service *and* benefits.

Subscription agreements, as well as descriptive brochures, define the benefits which the 40 member hospitals sponsoring Blue Cross and the 1,700 par-

ticipating physicians sponsoring Blue Shield deliver to our subscribers. In this primary function, our hospital-sponsors and our physician-sponsors insist upon a direct and confidential relationship with their patients. No other relationship would be acceptable to the medical profession or to the American people.

In service, just as with benefits, the shortest distance between two points is a straight line. This is axiomatic. Just as the hospitals and the doctors make sick people well through individual treatment, so Blue Cross and Blue Shield strive to communicate face-to-face with each and every subscriber. Once this precious personal contact is disturbed, our efforts become ineffective and unproductive. It is almost proverbial to say that to do our best we must be as close to our subscribers as our facilities will permit.

We are equipped in mind and in matter for our obligation in human relations. What is more important, we believe that our natural willingness to serve is, in the final analysis, our great strength in competition with commercial carriers in the health field. Whatever the problems and whatever the questions, we can depend upon our employees to find the answers. Each operational unit at Blue Cross and Blue Shield is, in effect, a service unit, and each employee, from receptionist to switchboard operator, is trained to direct a subscriber with a question to a department with an answer.

Of all the Blue Cross and Blue Shield Departments, "Subscriber Service" is closest to our public. At least five telephone clerks, assisted by specialists in general office procedure, screen the calls from subscribers. If a question is unusually complicated, the telephone clerks either funnel the call to another answer-center or, in the absence of an immediate decision, refer the call to correspondence clerks who gather necessary information and prepare detailed replies. Five full-time interviewers in another section of the department talk to the subscribers who come into our offices.

Despite our efforts, some subscribers bypass the Plan when they actually use hospital-medical-surgical benefits. Because they do not understand our

* Director, Maryland Hospital Service, Inc., Maryland Medical Service, Inc.

dual purpose, they think that with each admission and with each diagnosis the hospitals and the physicians should answer "Twenty Questions" about Blue Cross and Blue Shield. They forget, for a moment, that hospitals are crowded and that doctors are busy. Under the emotional impact of an overwhelming illness, they do not use the easy access to the Plan office.

If they stopped to think, they would realize that prepayment (the basic principle which sustains Blue Cross and Blue Shield) is a two-way street. In one direction, patients receive service benefits. In the other direction, subscribers receive beneficial services. But if, when subscribers become patients,

they go in only one direction—if they refer more than just their symptoms to the doctors and the hospitals—an unfortunate traffic jam can result.

Before our enrollment gets much larger, we must mark the lanes to an effective and productive use of Blue Cross and Blue Shield so clearly that subscribers will not impose upon our sponsors with general inquiries not related to actual patient care. To achieve the best results, we who administer Blue Cross and Blue Shield must depend upon the doctors and the hospitals, as much as upon our own resources, to bring subscribers home to their plan—through the direct line to service which awaits their use.

MANION COMMISSION PANEL STARTS SURVEY OF U.S. GRANTS

The AMA Washington Letter—No. 48

A panel of consultants to the Manion Commission has started a national sampling survey to "determine the composite impact of all federal aid programs in the state and local fields where the service is rendered." It will look into all programs where both federal and state or local funds are used, including vocational rehabilitation, grants for crippled child work and for the disabled and several other activities of medical interest.

On the basis of findings of the survey, and information from other sources, the commission expects to recommend changes designed to limit federal participation and stimulate more activity by the states and local communities.

The survey will involve only four or five states in five general areas of the country. According to the commission, it is the first time this technique has been applied to the problems of federal-state relationships.

Members of the commission are Arthur E. Buck, West Norwalk, Conn., an authority on public budgeting; Phillip Cornick (Ph.D.), Chicago, a governmental research consultant; Edward Litchfield, Ithaca, N. Y., dean of the School of Business and Public Administration, Cornell University; Herbert Simpson, (Ph.D.) Evanston, professor at Institute for Economic Research, Northwestern University.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. CHARLES H. WILLIAMS, *Auxiliary Editor*

SEMI-ANNUAL MEETING, 1953, BETHESDA, MD.

President's Message

MRS. JOHN G. BALL

I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals.

This is the pledge we say at Auxiliary meetings and which is always most impressive at the national conventions. There, we hear voices from every state in the union, Hawaii and Alaska pledging themselves to the work of the Auxiliary.

Now just what is that work? Those high ideals? Our constitution states our objects to be: (1) Through our members to extend the aims of the medical profession to all organizations which look to the advancement of health and health education; (2) To fulfill such functions as may be desired from time to time by the Medical and Chirurgical Faculty of the State of Maryland; (3) To promote acquaintanceship among physicians' families that fellowship may increase and at all times to stimulate a feeling of local cooperation. Each of these objects is important and vital to the medical profession in Maryland. No one member or one county can do this alone. Accomplishment of our objects depends on the willingness of each individual member to do her part.

At the National Convention in New York, June 1-5, 1953, we were shocked to learn that Maryland is at the very bottom of the list for Woman's Auxiliary Membership Percentage of the American Medical Association membership, that percentage being 23.5%. Now is the time for us, each and every one of us, to get busy and find those friends of ours in unorganized counties, visit them, talk with them about the Auxiliary, tell them our objects, the work we have been doing, and how rewarding the con-

tacts and friendships we make, become. Your Organization Chairman, Mrs. Albert E. Goldstein, and your President will be happy to visit or have any suggestions you may have. The most successful membership and organization work has just one secret—"personal contact and interest." At the Presidents' Conference following the New York meeting, Mrs. Leo J. Schaefer, our National President, gave us this theme: "Together we progress." Let us work together for progress in membership and organization.

As we strive for more members and more organized counties, let us not forget the work we have already started that needs our continuing support. In New York, we were proud to report our successful Future Nurses Convention held in Baltimore on May 12, 1953, when nearly 400 enthusiastic high school girls heard speakers on all phases of nursing, saw American Medical Association nursing films, and heard student nurses, in uniform, from 14 hospitals speak. All our organized counties have nursing scholarships. A Nurse Recruitment film is being made of the nursing schools in Maryland and will be ready for use this winter. Some of the high schools have Future Nurse Clubs which interest and teach the girls about nursing. More county Auxiliaries should sponsor these groups. In these ways we are meeting the challenge of the shortage of nurses which the American Medical Association has requested of us.

There are other continuing challenges for us; one of the greatest is in the field of Public Relations or "Public Responsibility" as one state has so aptly paraphrased it. Each doctor's wife needs to be informed and keep informed so she may be prepared to talk with the lay persons she meets daily, when questions are asked. Have you noticed that you can scarcely pick up a magazine but what there is some challenging article related to medicine, physicians, medical fees, malpractice suits, doctor shortage, emergency service and a host of other questions,

vital to us as physicians' wives and Auxiliary members. As individuals, we participate in many activities of educational, civic and religious organizations. All of these contacts are most important and should be extended. Public service is the ultimate goal of public relations. How best may we serve our communities in the field of health? The American Medical Association has been increasing its public service by developing voluntary health insurance, doctor placement service, emergency call systems, exposing quacks and continuing to look for a solution to the problem of the chronically ill, ageing, and mentally ill. Above all, we must continue to maintain the prestige and esteem of the medical profession in the eyes of the public.

Civil Defense needs our continuing greater interest and effort. Much of the organizational work has been completed so we should be able to see definite progress this year. Each one should find the place she may best help in her local organization.

Last year the American Medical Association asked the Auxiliary to help the American Medical Education Foundation with the problem of raising money for the medical schools of the country, most of which have large deficits. The National Auxiliary gave \$10,000 to the Foundation at the New York meeting. Efforts must be continued to meet the goal of \$2,000,000 for this year. Let us continue to urge all physicians to subscribe to their medical schools through the American Medical Education Foundation. All such money given by physicians through the Foundation is matched by funds subscribed by private industry. Speak to your husband about this.

To help us in all these important tasks, we have the "Bulletin of the Woman's Auxiliary to the American Medical Association." Each National Chairman through her contacts throughout the states and through the states to the counties has a wealth of information and help to offer each of us. The only way we can avail ourselves of this help is to subscribe to the "Bulletin." Until we all start reading and using the material presented to us, we are not beginning to do our job. If you do not subscribe, please do. The Bulletin Chairman, Mrs. S. Jack Sugar, 6709 41st Avenue, University Park, Maryland, will be happy to take your subscription for \$1.00.

Another object of the Auxiliary is being fulfilled with this Semi-Annual Meeting. The Auxiliary

helped with the planning and entertainment of this meeting as requested by the Medical and Chirurgical Faculty.

WAYS AND MEANS

After the Ball is Over

MRS. E. ELLSWORTH COOK*

The first Annual Medical and Chirurgical Faculty Ball is now just a memory but it was the wonderful climax to many months of planning, meetings, phone calls, and rehearsals. A year ago last summer when Mrs. Albert E. Goldstein, the President of the Woman's Auxiliary to the Baltimore City Medical Society asked me to be the Chairman of the Ways and Means Committee, I decided that a spring dance would be the most enjoyable way to raise funds. But, it always takes money to make money and the treasurer was unable to pay the many expenses connected with so costly an undertaking. Therefore, an affair had to be held in the fall to even consider plans for a dance. The Dessert Luncheon, Fashion Show, and Card Party in November netted us many new friends and slightly over five hundred dollars. Now, we were ready!

At the end of November, a meeting was held of the Ways and Means Committee members with their husbands, and the three advisors from Baltimore City Medical Society along with their wives to ask for the cooperation and advice of the organized medical profession. They were in favor of the idea and agreed to ask permission of the City and State Society, which was forthcoming. Dr. Edwin H. Stewart, Jr. deserves the credit for the idea to make the Ball an annual affair in conjunction with the Annual Meeting of the Faculty. Monday evening was chosen to enable as many county members as possible to attend. Everyone was in favor of having the dance at the Faculty Building to save expenses but the accommodations were too limited and the date conflicted with the scientific sessions, hence the Alcazar was chosen.

One of the biggest headaches and later heartaches was the question of the Federal Amusement tax of 20%. None of us felt we should be compelled to collect and pay that tax. Certainly, none of the money

* Chairman, Ways and Means Committee.

we made was for personal use; it was going to be used for educational and charitable purposes. I called the Baltimore office of the United States Amusement Tax Division and was told the Auxiliary did not fulfill the requirements for tax exemption. However, it was suggested that I write to Washington and send along a copy of the Constitution and By-Laws and a yearly Treasurer's report. Anxious months passed and finally word was received the Auxiliary would be required to pay the tax.

The "motif" for our Ball came about by a spontaneous brain-storm between Mrs. Irving J. Taylor and myself. During one of our innumerable phone calls, I suggested a Spanish side-walk café setting for the supper room in the Faculty Building. (This was before the decision to use the Alcazar.) I felt that those guests having to be seated downstairs should be compensated with an attractive atmosphere. Mrs. Taylor was in agreement but said that sidewalk cafés reminded her more of France than the Spanish countries. That was it! Our theme! We would invite the guests to spend "An Evening in Paris." The rest was easy and in the following few minutes we planned the "Folies Baregere" with the can-can girls and boys, the Apache dancers (Will anyone ever forget the hit made?), the lovely songs of Mrs. Robert Goldstein, Dr. Hymen Rubin and Mrs. John J. Erwin, the Merry Widow Waltzers, and the lavish showing of fashions from Schleisner and Company. If I say the "Folies" were planned in a short time, I do not mean to give the impression that it came into actuality that easy. From that day until the end of April, Mrs. Taylor's time and talents were wholeheartedly donated to produce an entertainment worthy of the best ability of every member of the cast. She wrote new words to two songs, along with the dialogue of the able Master of Ceremonies, Dr. Louis J. Kolodner. She devised the choreography of the can-can and the waltz and taught and rehearsed the dancers and singers. Lastly, the main burden of casting the show was hers. Everyone who enjoyed the "Folies" owes her a tremendous debt of gratitude.

The biggest problem facing me as Chairman was to find able members who were willing to head committees. As far as possible, I had hoped to have a program with a patron list and advertisers in order to cover the expenses of several thousand dollars without using funds from the Treasury. If you can

do this a large balance is not necessary in order to plan an undertaking of this kind. Our program, due to the hard work of the Chairman, Mrs. John B. DeHoff, and her Patron Chairman, Mrs. J. Arthur York, and Special Contributions Chairman, Mrs. Edwin H. Stewart, Jr., netted us well over one thousand dollars. We asked for special contributions from those business firms which we felt would directly benefit from advertising to the medical profession such as drug stores, medical supply houses, and pharmaceutical firms, etc.

Another idea I had for added proceeds was to combine a bazaar with our Ball. In keeping with the French motif the bazaar area was called the "Rue de la Paix" and French perfume, jewelry, fashion accessories, cosmetics, paintings, cakes and candy, Nurse dolls, etc., were offered for sale. Some of the articles sold very well (the Nurse dolls) but for the most part the sales were disappointing and not worth all the trouble involved. Personally, I felt that the majority of the guests at a Ball would rather enjoy themselves dancing and being among friends than in buying merchandise.

The distribution of tickets was a major accomplishment and ably handled by Mrs. Richard M. Garrett and her committee. Each physician member of the Faculty was invited to be a patron by a personal letter and two tickets were enclosed. It was felt that even though many could not attend, they believed in what we were trying to do and wanted to contribute. Tickets were also available at our Auxiliary meetings and at the door of the Alcazar for the convenience of those guests who wanted extras at the last minute.

Extensive publicity is a *MUST*! The newspapers of Baltimore were contacted as far as possible in advance of the April date to insure full coverage. Each paper promised one picture. Mrs. J. Carlton Wich, the Chairman, felt that publicity pictures should be of different committees and performers in the show. Altogether, there were eight or nine columns in the papers and several pictures. I was able to obtain permission from three different television stations to include acts from the "Folies" on three of their widely viewed programs. Those of us who appeared on TV got a lot of fun out of it and found it is not as frightening as it seems. The Maryland Medical Journal was our best source of publicity to try to convince the doctors and their families they

should not miss our Ball. Numerous articles and a picture were printed. I am truly grateful for the help of Mrs. George H. Yeager, the Auxiliary Journal Editor who was always willing to take time out of her very busy schedule to assist me in composing the various letters I was called upon to write. I sent a letter to the French Ambassador in Washington asking him to be our Guest of Honor and he was quite distressed that he couldn't accept the invitation. The Mayor, Governor, and two Senators were also invited but could not attend.

Didn't the Alcazar look beautiful? Those of you who were present, have you ever seen it more lavishly decorated? Mrs. Raymond Markley, Jr. and her committee worked all day trying to transpose it into an atmosphere of gay Pareé. The results looked magnificent, even down to the tiny Eiffel Tower table decorations. I knew the evening would be a success the minute I saw the Ballroom. No one could help having fun in that setting.

I have written this article to help other Auxiliaries plan an affair such as ours and have only briefly touched on the detailing of the work involved. We were able to cut expenses by several ways such as being fortunate enough to purchase the set-ups at less than cost and sell them for profit. Also we hired a non-union orchestra and were pleased to be able to save over one hundred dollars on their fee. Many

important committees I have had to omit, such as the refreshments, flowers, raffle, etc., but they all contributed to our final net figure of slightly better than twenty-two hundred dollars profit. We did not give our Ball primarily for monetary proceeds but rather to have a pleasant evening renewing acquaintances with old friends and colleagues. But we are proud to report the distribution of the profits as follows:

\$500.00 to the Building Fund of the Medical and Chirurgical Faculty of Maryland

\$500.00 to the American Medical Education Foundation

\$500.00 to the Woman's Auxiliary of the Maryland Medical and Chirurgical Faculty

\$300.00 for a full Nursing Scholarship

\$100.00 for the Nurse Recruitment Film the Woman's Auxiliary to the Baltimore City Medical Society is sponsoring.

The plan for next spring's Medical and Chirurgical Ball is already taking shape in a little corner of my mind and I hope it will be even better than last year's. I need everyone who can to volunteer to serve on the committees and talented medics and their families for the show. Only with the wholehearted support of the Auxiliary wives and their physician husbands throughout Maryland can an evening of this type be eminently successful.

Reports

JOINT ANESTHESIA STUDY COMMITTEE OF THE

Baltimore City Medical Society and the Baltimore City Health Department

OTTO C. PHILLIPS, M.D.*

Through the joint efforts of Dr. Wetherbee Fort, President, the Baltimore City Medical Society and Dr. Huntington Williams, Commissioner of Health, The City of Baltimore, The Joint Anesthesia Study Committee was appointed on April 20, 1953. The present membership of the Committee is as follows:

1. Dr. Robert Dodd, Professor of Anesthesiology, The University of Maryland School of Medicine.
2. Dr. Donald Proctor, Professor of Anesthesiology, The Johns Hopkins Medical School.
3. Dr. Edward I. Lederman, Chairman of the Anesthesiology Section of the Baltimore City Medical Society.
4. Dr. Russell Nelson, Director, The Johns Hopkins Hospital, President of the Baltimore Hospital Conference.
5. Dr. Matthew Taback, Director, Statistical Section, The Baltimore City Health Department, and Secretary of the Committee.
6. Dr. Russell S. Fisher, Chief Medical Examiner of Maryland.
7. Dr. John C. Krantz, Professor of Pharmacology, The University of Maryland School of Medicine.
8. Dr. Joseph Leo Lilienthal, Jr., Associate Professor of Medicine, The Johns Hopkins Medical School.
9. Dr. Huntington Williams, Commissioner of Health of Baltimore.

* Chairman, The Joint Anesthesia Study Committee.

10. Dr. Cless Y. Fordyce.
11. Dr. Frank Brady.
12. Dr. Otto C. Phillips, *Chairman*.

The Committee held its first meeting on April 25, 1953. As a result of this meeting, and of subsequent sub-committee meetings, the following plans were agreed upon:

1. **OBJECTIVE OF COMMITTEE.** The purpose of the Committee is to discuss every death in this City that occurs the day of or the day after operation for the purpose of uncovering repetitive errors and for the dissemination of information on errors. In no case will the Committee attempt to identify any individual or hospital.
2. **REPORTING OF CASES.** Cases referred consist of *all* deaths which meet the above specifications. The flow of information is initiated through the Statistical Section of the Health Department by a study of the data appearing on the death record. A study form is sent the hospital and a case number assigned the patient. Upon the return of this study form to the Committee, the only link between the case number and the hospital is in the files of the Health Department.
3. **MEETINGS.** Monthly meetings will be held on the third Wednesday of each month at 8:30 P.M. at 1211 Cathedral Street. Protocols are prepared by a sub-committee and presented to the group at large for discussion.

Requests for case studies began on August 1, 1953. As of November 1st 48 requests had been submitted with 35 returns, which is a gratifyingly high degree of response and cooperation. The first discussion meeting was held in October. They have been and will continue to be held regularly.

COMING MEETINGS

THE EYES OF THE WORKER

OCCUPATIONAL VISION CONFERENCE,
1211 CATHEDRAL ST.

Wednesday and Thursday, March 3 and 4, 1954.

In an effort to show how production, safety and employees' health and satisfaction can all be increased by recognition of the factors that affect his ability to see well on the job, the University of Maryland is planning an Occupational Vision Conference to be held March 3 and 4, 1954, at the Medical and Chirurgical Faculty Building at 1211 Cathedral Street, Baltimore, Maryland.

The Ophthalmological Section of the Baltimore City Medical Society has found this project to be of such a nature that we have become one of the participating agencies sponsoring this program. The conference will attempt to point out the advantages to be gained from occupational vision programs by means of talks, panel discussions and exhibits. It is expected to attract attendance from representatives of industry and commerce as well as ophthalmologists, optometrists and illuminating engineers. It will be of special interest to management representatives of business and industry, heads of medical departments, efficiency experts, personnel managers and safety directors.

It is rather interesting to note that one out of every three employees is visually unqualified for satisfactory performance in his job. This has been proven true by many hundreds of thousands of visual performance tests. The employee who has been indoctrinated in an occupational vision program will carry this information into his day to day living. In traffic accidents alone, studies have found that visual deficiencies are at the top of the list of physical ailments as factors in accidents involving drivers who report repeated number of accidents.

This type of program has a dollar value to industry as well as a value for the recipient that cannot be counted in dollars and cents. Programs have been established and have proved their worth in many business organizations. In one organization, it was shown that 57% of the people with defective vision are poor producers. Such a program

reduced accident costs in one department by 40% and in one job reduced rejected work by 50%. The programs are geared to cover all types of operations, including the period of training. In one company, training time was cut in half and the absenteeism was reduced by 62%. The need for an occupational vision program exists in every company, big and small.

As an employee grows older, the more valuable he becomes, due to his experience and "know-how." By the same token, the older the employee, the more need he has for an occupational vision program. The U. S. Public Health Service has made studies which definitely show that the entire population is subject to a gradual reduction of visual adaptability with age increase.

PAN AMERICAN CONGRESS OF OPHTHALMOLOGY IN SÃO PAULO, BRAZIL

Plans are well advanced for the Third Interim Congress of the Pan American Association of Ophthalmology, which is to be held in São Paulo, Brazil, June 17-21, 1954.

Dr. Moacyr E. Alvaro, São Paulo, president of the Association, has announced that the scientific sessions of the Congress will be devoted to presentation of recent advances in treatment of diseases of the eye and in the prevention of blindness.

Meeting concurrently in São Paulo will be the Eighth Brazilian Congress of Ophthalmology and the Nineteenth International Congress of Oto-Neuro-Ophthalmology.

Simultaneous translations in English, Spanish and Portuguese will be provided for the sessions of the Interim Congress, to enable those present to hear the scientific papers and other proceedings in the languages they know best.

Many social events have been planned, including opportunities to enjoy typical Brazilian experiences, which will be of particular interest because São Paulo is celebrating its fourth centennial this year. For example, there will be a presentation of Brazilian dances and a visit to a coffee plantation. Physicians

who register for the Congress before the end of February 1954 will receive invitations to dinner parties in the homes of Brazilian physicians.

There will be a registration fee of \$10, which will cover many of the events, including attendance at the other two congresses. Attendance is not restricted to members of the Association, according to Dr. Alvaro.

The Pan American Association of Ophthalmology was founded in 1939 through the initiative of the late Dr. Harry S. Gradle of Chicago and Dr. Alvaro. The world was then at war, and it was evident that international meetings would be suspended indefinitely. With the sponsorship of the American Academy of Ophthalmology and Otolaryngology,

a committee consisting of Dr. Gradle, Dr. Alvaro and Dr. Conrad Berens of New York organized the first congress, which was held in Cleveland in 1940. The second was held in Montevideo, Uruguay, in 1945 after the close of the war; the third in Havana, Cuba, in 1948, and the fourth in Mexico City in 1952.

As interest increased, the interval of four years between congresses appeared too great, and it was decided that interim meetings would be advantageous. The first of these was held in Miami Beach, Florida, in March 1950, in conjunction with the annual meeting of the National Society for the Prevention of Blindness (U.S.A.). The second took place on a Caribbean cruise in January 1953.

SECTION ON DISEASES OF THE CHEST

A. MURRAY FISHER, M.D., *Chairman*

EDMUND G. BEACHAM, M.D., *Secretary*

Wednesday, March 3, 1954, 8:00 p.m.

1211 Cathedral Street

Treatment of Pulmonary Emphysema. DOUGLAS G. CARROLL, M.D., Assistant Professor of Medicine, The Johns Hopkins University School of Medicine, and Assistant Chief of Medicine, Baltimore City Hospitals. (Illustrated.)

OTOLARYNGOLOGICAL SECTION

C. CARLETON DOUGLASS, M.D., *Chairman*

ALBERT STEINER, M.D., *Secretary*

JOINT MEETING WITH OTOLARYNGOLOGICAL SECTION OF THE DISTRICT OF COLUMBIA MEDICAL SOCIETY

Tuesday, March 9, 1954

Johns Hopkins Club, Homewood Campus

Cocktails 6:00 p.m. Dinner 6:30 p.m.

My Experiences with a Non-Operative Treatment of Chronic Sinusitis and Nasal Polyps. Samuel J. Crowe, Emeritus Professor, Otolaryngology, The Johns Hopkins University School of Medicine.

Discussion by Walter L. Winkenwerder, M.D., Assistant Professor of Medicine, The Johns Hopkins University School of Medicine.

CANCER SECTION

EDWIN H. STEWART, JR., M.D., *Chairman*

ARTHUR G. SIWINSKI, M.D., *Secretary*

Wednesday, March 10, 1954

National Institutes of Health, Bethesda

Notice will be sent.

MARYLAND PSYCHIATRIC SOCIETY

1211 Cathedral Street, Baltimore

LEONARD J. GALLANT, M.D., *Secretary**Thursday, March 11, 1954, 8:30 p.m.*

Observations on the Role of Depressive Mechanisms in Certain Patients with Disseminated Lupus. ROBERT MCCLARY, M.D., Instructor in Psychiatry, The Johns Hopkins University.

Discussants: MAURICE H. GREENHILL, M.D., Associate Professor of Psychiatry, University of Maryland. LAWRENCE E. SHULMAN, M.D., Assistant in Medicine, The Johns Hopkins University.

RADIOLOGICAL SECTIONDAVID N. GOULD, M.D., *Chairman*H. LEONARD WARRES, M.D., *Secretary*

The Radiological Section of the Baltimore City Medical Society does not plan on holding a meeting in March since the Eastern Conference of Radiologists will be holding their meeting on the twelfth and thirteenth of March at the Statler Hotel in Washington, D. C.

ANESTHESIA STUDY COMMITTEE

1211 Cathedral Street, Baltimore

Wednesday, March 17, 1954, 8:30 p.m.

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department.

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty.

RICHARD W. TELINDE, M.D., *Chairman*BEVERLEY C. COMPTON, M.D., *Secretary*

1211 Cathedral Street, Baltimore

*Thursday, March 18, 1954, 5:00 to 6:00 p.m.***BALTIMORE CITY MEDICAL SOCIETY**LEWIS P. GUNDRY, M.D., *President*AMOS R. KOONTZ, M.D., *First Vice President*EDWARD F. COTTER, M.D., *Secretary*ROBERT C. KIMBERLY, M.D., *Treasurer*GRANT E. WARD, M.D., *Second Vice-President**Friday, March 19, 1954, 8:30 p.m.**Osler Hall, 1211 Cathedral Street***PANEL DISCUSSION: THE USES AND ABUSES OF ACTH AND CORTISONE**

A. McGehee Harvey, M.D., *Moderator*, Professor of Medicine and Director of the Department of Medicine, The John Hopkins University School of Medicine.

Participants:

Joseph L. Hollander, M.D., Assistant Professor of Clinical Medicine and Director of the Department of Medicine, University of Pennsylvania School of Medicine, and Assistant Professor of Internal Medicine, The Medico-Chirurgical College, Postgraduate School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania.

Lawrence E. Shulman, M.D., Assistant in Medicine, The Johns Hopkins University School of Medicine.

Alan C. Woods, M.D., Professor of Ophthalmology and Director of the Department of Ophthalmology, The Johns Hopkins University School of Medicine.

Leslie N. Gay, M.D., Associate Professor of Medicine, The Johns Hopkins University School of Medicine.

Raymond C. V. Robinson, M.D., Instructor in Medicine and Assistant in Dermatology, The Johns Hopkins University School of Medicine.

* * * *

Question Period

DERMATOLOGY SECTION

RAYMOND C. V. ROBINSON, M.D., *Chairman* WILLIAM R. BUNDICK, M.D., *Secretary*

Monday, March 22, 1954, 8:30 p.m.

1211 Cathedral Street, Baltimore

1. Present Status of Local Hydrocortisone Therapy, by H. M. Robinson, Jr., M.D. and R. C. V. Robinson, M.D.

Discussion opened by Eugene Bereston, M.D.

2. Uses of High Frequency Vacuum Machines for Hypertrichosis, by F. A. Ellis, M.D.

Discussion opened by Albert Schapiro, M.D.

MATERNAL MORTALITY COMMITTEE

1211 Cathedral Street, Baltimore

Thursday, March 25, 1954, 4:00 to 5:00 p.m.

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the Baltimore City Health Department.

DR. JACK W. KOLSON MEMORIAL LECTURE (FOURTH RENEWAL)

Sponsored by House Staff of Sinai Hospital

Thursday, March 25, 1954, 8:30 p.m.

Hurd Hall, The Johns Hopkins Hospital

Approaches to Chemotherapy of Cancer. SIDNEY FARBER, M.D., Professor of Pathology, Harvard University School of Medicine, Boston, Massachusetts.

MARYLAND ACADEMY OF GENERAL PRACTICE

The date for the spring meeting of the Maryland Academy of General Practice in Hagerstown, is Thursday, May 13, 1954.

Dr. Robert P. Conrad, Hagerstown, has been appointed Chairman of the local Committee on Arrangements.

If there is any change in the date of the meeting there will be a notice to this effect.

William T. Layman, M.D., Secretary

Maryland Academy of General Practice

A.M.A. NEWS RELEASE—WASHINGTON OFFICE

Washington, D. C.—Although the budget, defense and farm policy are monopolizing Washington headlines, Congress is paying more than casual attention to the health and social security fields. In these, as in other legislative areas, it has for its guidance a specific program, laid down by President Eisenhower in his various messages during the first few weeks of the session. The question now is whether this closely-divided Congress will have the time and/or the inclination to follow through on everything the Administration wants.

Before Congress settled down to its task, the President met with a group of American Medical Association leaders, who discussed with him the Association's position on several important pieces of legislation. Present at the White House meeting, in addition to Mr. Eisenhower and Sherman Adams, Assistant to the President, were AMA President Edward J. McCormick, Trustees' Chairman Dwight H. Murray, President-Elect Walter B. Martin, and Washington Office Director Frank E. Wilson.

Congress got into the health and welfare field with no waste of time. Within five days after Congress reconvened the House Interstate and Foreign Commerce Committee, under the chairmanship of Rep. Charles Wolverton (R., N. J.), began an exhaustive series of hearings on voluntary health insurance, further evidence that the Administration is determined to get some action in this direction.

Chairman Wolverton as long as four years ago was interested in legislation to help pre-paid insurance programs extend their coverage and increase their benefits. In 1950 he incorporated his ideas in a bill, but it was not acted upon by the committee and was not revived until this year. Now the atmosphere is much more favorable for Mr. Wolverton's proposal. Not only is he chairman of the committee and his party in control of Congress, but his ideas have strong support from the Administration.

Basically the Wolverton idea is an FDIC for voluntary health insurance. In about the same way the Federal Deposit Insurance Corporation insures bank deposits up to a certain limit, the Wolverton program would insure (or re-insure) various types of hospital, surgical, and medical insurance programs. The proposal is for the federal government to set up a national health insurance underwriting corporation. To keep the corporation going, the member plans would contribute a certain percentage of their gross receipts, possibly 2%.

With the national corporation underwriting unusual risks, the individual programs could offer catastrophic or "complete" coverage. By scaling individual premiums to the family income, the member plans also could offer protection to families with very low incomes. The national corporation would pay possibly two-thirds of each subscriber's claim in excess of, say, \$500 or \$1,000 in any one year.

Another piece of legislation, receiving favorable attention, also would help families with their medical expenses—a proposed liberalization of income tax deductions allowed for medical expenses. Under present law, only that part of medical expense exceeding 5% of taxable income may be deducted. The pending legislation would drop this to probably 3 per cent, and raise or eliminate the maximum limit. In past years scores of bills pointed in this direction have been introduced. If this is incorporated in the general tax overhaul legislation, it is believed to have a good chance of enactment.

Secretary Hobby's Department of Health, Education and Welfare is firmly behind a proposal to have the federal government show more leadership in vocational rehabilitation of the handicapped. At this writing it is too early for any good indication as to whether physicians will be brought under social security. The Administration's bill would blanket in most self-employed groups, including dentists, attorneys, architects and farmers, in addition to physicians. Rep. Carl Curtis (R., Neb.), chairman of the subcommittee which investigated social security, apparently feels the same way. However, a substantial number of the members

of the House Ways and Means Committee, which must pass on the bill, are known to feel that compulsion should not be used on groups that do not want Old Age and Survivors Insurance.

From all indications available during the first few weeks of Congress, a showdown fight may be unavoidable on medical care for military dependents. Defense Department, with support from the President, wants dependent care extended and made uniform among the three services, with military physicians carrying as much of the responsibility as they can. Under the Defense Department plan, dependents who could not be taken care of at military installations would be allowed to obtain their care from private sources, with the government paying almost all of the cost.

The American Medical Association agrees with the Defense Department that all dependents should receive medical benefits as nearly uniform as possible. However, AMA contends that wherever possible dependents should use private physicians and private hospitals, and that the military personnel and facilities should be employed only where civilian facilities are inadequate.

EARLY REMINDER
Med-Chi Faculty Ball

APRIL 26, 1954

THE ALCAZAR



Dance 9 p.m.—1 a.m.

Variety Show 10 p.m.—“MEDICANA”

Coronation of Baltimore’s “*Outstanding Student Nurse*”

Raffle of Mink Stole!

MARK THESE DATES ON YOUR CALENDAR

PLAN TO ATTEND

The Annual Meeting
of the Medical and Chirurgical Faculty

⇨ April 26, 27 and 28, 1954 ⇩

Business Meetings, Monday, April 26, 1954 and Wednesday, April 28, 1954.

Scientific Sessions, Tuesday, April 27, 1954 and Wednesday, April 28, 1954.
Day and Evening Meetings. Also Round Table Luncheon and Buffet Supper.

The first article in the March Journal will contain a preview of the Annual Meeting, and the usual program will be mailed in April about two weeks prior to the Meeting.

Maryland

STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 3

March, 1954

NUMBER 3

ANNUAL MEETING

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

April 26, 27 and 28, 1954

All business sessions of the Annual Meeting will be held on Monday morning and Monday afternoon, April 26th, with the exception of a short business meeting on Wednesday morning, April 28th. Between the morning and afternoon meetings of the House of Delegates on Monday, a luncheon will be served to the members of the House of Delegates.

Mrs. E. E. Cook, Chairman of the Med-Chi Faculty Ball Committee of the Woman's Auxiliary to the Baltimore City Medical Society, has again arranged for the Ball on Monday evening, April 26th, at the Alcazar. Those who attended this gala affair last year will certainly be among those present, and those who missed it, will be among the first to make their reserva-



WILLIAM L. GARLICK, M.D.



BEVERLEY C. COMPTON, M.D., *Chairman*



EDWIN H. STEWART, JR., M.D.

Committee on Scientific Work and Arrangements

tions this year. There will be a floor show, which will equal or surpass last year's. There will also be the "Coronation of Baltimore's Outstanding Student Nurse."

The House of Delegates will meet at 1212 Cathedral Street, as it did in 1953, due to the lack of space in the Faculty Building. All other functions will be in the Faculty Building, with the exception of the Round Table Luncheon, which will be held at the Sheraton-Belvedere Hotel.

The Committee on Scientific Work and Arrangements, consisting of Dr. Beverley C. Comp-ton, Chairman, Dr. William L. Garlick and Dr. Edwin H. Stewart, Jr., are planning to have outstanding speakers and subjects of interest to all members of the Medical and Chirurgical Faculty.

On Tuesday and Wednesday mornings, from 9 a.m. to 10 a.m., Dr. Garlick has obtained interesting motion pictures. On Tuesday, from 10 a.m. to 12 noon, there will be a Psychiatric Panel on problems common to the general practitioner. The following will participate: Dr. Harry M. Murdock, Moderator, Dr. Frank J. Ayd, Jr., Dr. Klaus Berblinger, and Dr. Clifton T. Perkins.

The Johns Hopkins University School of Medicine will present a Clinical Pathological Conference on Tuesday from 2 p.m. to 3 p.m., following which there will be a Chemotherapy Panel with Dr. John C. Krantz, Jr. as the Moderator. Dr. Gladys L. Hobby, Dr. Edward P. Steers, and Dr. Henry Welch will participate on the Panel.

Dr. Bender B. Kneisley will give his Presidential Address, "Our Relations with the Public," at 8 p.m. on Tuesday evening. Following the Presidential address, Dr. Paul Dudley White of Boston will speak. In addition, a portrait of Dr. John Ruhrah will be presented.

On Wednesday morning, from 10 a.m. to 12 noon, there will be a panel discussion on Cancer, and in the afternoon from 3 p.m. to 5 p.m. there

will be a Diabetes Panel. The participants on these two Panels will be announced later. There will also be a Clinical Pathological Conference presented by the University of Maryland School of Medicine from 2 p.m. to 3 p.m. on Wednesday.

Due to popular demand the Committee has again arranged to have a Round Table Luncheon, which will be held at the Sheraton-Belvedere Hotel on Wednesday at 12:30 p.m. At this writing the following have accepted to assume the "host" position:

Dr. Warde B. Allan—Chemotherapy and Antibiotics
 Mr. G. C. A. Anderson—Civil Malpractice
 Dr. James G. Arnold—Common Neurological Lesions
 Dr. Edmund G. Beacham—Common Tuberculosis Problems
 Dr. E. S. Bereston and Dr. R. C. V. Robinson—Removal of Acne Scars (Plastic Planing)
 Dr. John E. Bordley—Nose and Throat
 Dr. Dexter M. Bullard—Psychoneuroses
 Dr. T. Nelson Carey—Diabetes
 Dr. William K. Diehl—Office Gynecology
 Dr. Monte Edwards—Proctology
 Dr. Albert E. Goldstein—Urology
 Dr. Nathan B. Herman—Industrial Medicine
 Dr. John Eager Howard—Endocrinology
 Dr. Hugh J. Jewett—Urinary Tract Cancer
 Dr. Howard W. Jones—Gynecological Carcinoma
 Dr. D. Frank Kaltreider—Breech Presentation
 Dr. Amos R. Koontz—Hernia
 Dr. John C. Ozazewski—Common Eye Problems
 Dr. Harry M. Robinson, Jr.—Common Skin Diseases
 Dr. Milton S. Sacks—Usual Laboratory Procedures in Clinical Diagnosis
 Dr. Alexander J. Schaffer—Poliomyelitis
 Dr. Douglas H. Stone—Pediatric Acute Surgical Abdomen
 Dr. Caroline B. Thomas—Hypertension
 Dr. Charles W. Wainwright—Arthritis
 Dr. Grant E. Ward—Head and Neck Cancer
 Dr. Lawson Wilkins—Pediatric Endocrinology
 Dr. Huntington Williams—Public Health
 Dr. Walter L. Winkenwerder—Allergies

Additional Round Tables are being planned, but all acceptances have not been received at the time of this announcement.

From 6 p.m. to 7 p.m. on Wednesday there will be a buffet supper, followed by a meeting with an address designed to be of interest to the members and their wives. As has been customary in the past, the President of the Woman's Aux-

iliary to the Medical and Chirurgical Faculty will be presented at this meeting.

Dr. Edwin H. Stewart, Jr. has arranged the commercial exhibits. These will be held in the tent and in the small meeting room on the lower floor of the Faculty Building.

A brand new feature—Every physician is urged to register and receive a number, as there will be

a drawing on Wednesday evening for two one hundred dollar bonds.

As you can see from the above outline, the Committee has given a great deal of thought to the preparation of this program. It is hoped that the Annual Meeting this year will be well attended, thereby assuring it as an outstanding event of the Medical and Chirurgical Faculty.

HAVE YOU PAID YOUR AMA DUES?

Resolution Adopted.

The House of Delegate of the AMA in December 1953, at the interim meeting adopted the resolution submitted by its Reference Committee on Amendments to the Constitution and Bylaws:

“Resolved, that any active member of the American Medical Association who failed to pay dues for the year 1950, and who was suspended for such delinquency, may be reinstated during the first six months of 1954 by payment of 1954 dues only.

Should such an individual fail to pay his 1954 dues by July 1, 1954, he shall continue to be considered delinquent.”

Please note that the above resolution will be in effect *only* to July 1, 1954; after that date such members will again be held liable for the payment of 1950 dues if they wish to be reinstated to active membership in the A. M. A.

At this time the A. M. A. is dropping from the membership roster those physicians who have not paid 1953 dues. These physicians are being given the option of three actions:

1. To pay \$50.00 to cover membership dues in the A. M. A. for 1953 and 1954, to continue as an active member in good standing or
2. To pay \$30.00 to cover THE JOURNAL, AMA for 1953 and 1954; and be listed as a delinquent member for 1953 or
3. To pay \$15.00 to cover THE JOURNAL for 1953, to the end of the year; and be listed as a delinquent member for 1953 and THE JOURNAL stopped.

Physicians who elect either (2) or (3), will be expected to pay \$10.00 to complete the 1935 membership fee if they wish to be reinstated as a member in a future year, along with the payment required for the current year's dues.

Scientific Papers

Acute Poliomyelitis in Maryland

CLINICAL MANAGEMENT

MARTIN A. HOFFMAN, M.D.¹ AND LAURENCE FINBERG, M.D.²

Since the winter of 1949 the contagious disease center for most of Maryland has been Baltimore City Hospitals. This report is confined to experience with poliomyelitis during that period. In operating a modern communicable disease service, poliomyelitis is the only disease which is likely to present the hospital with a sudden large influx of patients. Although the season is predictable, the community incidence is extremely variable and capricious. Moreover the percentage of patients who will be seriously ill may vary considerably. Because we felt that the physicians of Maryland would be interested in the problem of hospitalization of patients with poliomyelitis, this summary of the clinical picture as we have seen it over the past four seasons is being presented. The scope of this paper is to define clearly the role of a communicable disease service of a general hospital.

During annual outbreaks of poliomyelitis the institution serves a dual role: first, to provide hospitalization for patients in the acute phase of the illness and such early convalescent care as may be indicated; secondly, to function as a diagnostic center to which physicians in Baltimore and in the various counties (particularly those who by their proximity or lack of facilities are in need of such a center) may refer patients for the necessary procedures and consultation to establish a diagnosis.

¹ Resident in Pediatrics, Baltimore City Hospitals.

² Assistant Chief of Pediatrics, Baltimore City Hospitals and Instructor in Pediatrics, Johns Hopkins University School of Medicine.

Since 1950 there have been 761 patients with poliomyelitis admitted. This accounts for a large proportion of the patients with poliomyelitis hospitalized in both Baltimore and Maryland. Statistics for 1953 from the Baltimore City Health Department and the State Health Department reveal that hospitals within the city of Baltimore (excluding Baltimore City Hospitals) admitted 17 patients with poliomyelitis and hospitals in the various counties admitted 20 such patients.³

During each poliomyelitis season the facilities of Baltimore City Hospitals are utilized for the referral of suspected cases of poliomyelitis. By performing diagnostic lumbar punctures, and such hematological and radiological studies as seem indicated, efforts are made to provide a diagnosis. The majority of those patients diagnosed as having poliomyelitis are admitted to the hospital. Those not admitted may fall into one of two categories: (1) patients without paralysis whom the physician feels will probably not develop muscular weakness and who may be readily managed at home and (2) patients with paralytic poliomyelitis who are past the acute phase of their illness and for whom arrangements can be made for the necessary physical therapy when indicated.

Emphasis is placed on admitting to the hospital all poliomyelitis patients in the acute phase of their illness who have definite or suspected

³ This excludes Montgomery and Prince George Counties, who had 44 and 33 patients, respectively, admitted either to local hospitals or to hospitals in Washington, D. C.

bulbar involvement. These patients may present with difficulty in swallowing, nasal voice, facial nerve weakness, accumulation of pharyngeal secretions or ophthalmoplegia. Weakness of muscles innervated by the upper cervical cord or the presence of encephalitic manifestations are ominous additional warning signs.

Confirmation of the referring diagnosis has been made in approximately two thirds of those patients sent in as having poliomyelitis. Among the remainder a variety of other illnesses was diagnosed and the patient was either admitted to Baltimore City Hospital or referred back to his physician. These illnesses included: acute bacterial and tuberculous meningitis, polyn neuritis, meningismus accompanying pneumonia, rheumatic fever, acute osteomyelitis, lead poisoning, viral encephalitis (especially mumps), fractures, soft tissue trauma, and hysteria.

WEEKLY ADMISSION RATES

A graph (Fig. 1) presents a comparison of weekly admissions of poliomyelitis patients to Baltimore City Hospitals in each of the three peak years 1950, 1952, and 1953.

GEOGRAPHICAL DISTRIBUTION OF PATIENTS

Table I presents the number of poliomyelitis patients admitted annually from 1950 through 1953 to the medical and pediatric services from the city of Baltimore and from various counties within the state. In the four year period 53% of those admitted were residents of Baltimore, 27% of Baltimore County, and the remaining 18% of 18 other counties.

CLINICAL CLASSIFICATION OF PATIENTS ADMITTED

The various categories of poliomyelitis patients admitted to each service in the four year period is illustrated in Table II. The diagnosis of non-paralytic poliomyelitis is (except where virological laboratory facilities are available) a presumptive one with or without epidemiological support. Wherever possible efforts have been made to exclude other causes of similar cere-

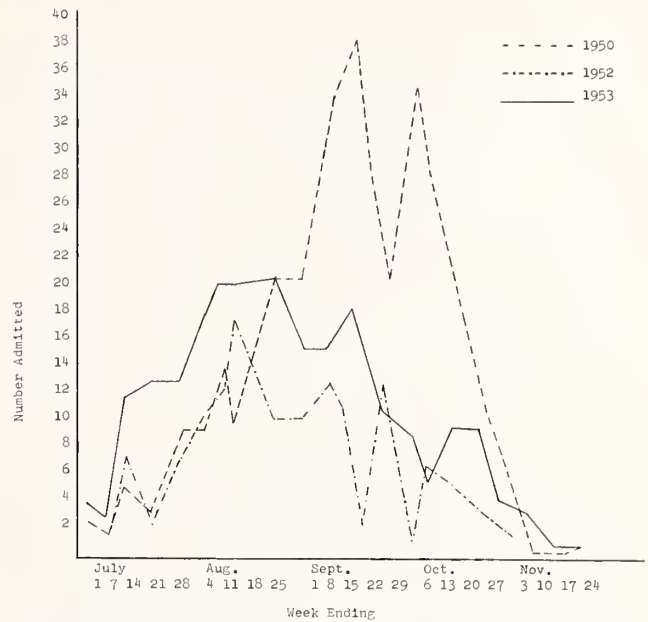


FIG. 1. Weekly admissions of poliomyelitis patients—1950, 1952, 1953

TABLE I

Geographical Distribution of Patients

AREA	1950		1951		1952		1953		TOTAL
	M	P	M	P	M	P	M	P	
Baltimore City...	47	168	4	12	12	45	28	86	402
Counties of Maryland:									
Allegany.....	1								1
Anne Arundel..	2	9	1			4	1	15	32
Baltimore.....	22	60	3	4	6	36	30	59	220
Calvert.....								1	1
Caroline.....								1	1
Carroll.....		6			1	1	2	2	12
Cecil.....		1				1		1	3
Charles.....				2				2	4
Frederick.....	2	3			3	10	2	3	23
Harford.....		7		1	1	6		3	18
Howard.....	2	1			1		3	5	12
Pr. George....		1							1
Queen Anne....						1		5	6
St. Mary's....	2	1				1		2	6
Somerset.....		2							2
Talbot.....								2	2
Washington....					1		1	1	3
Wicomico.....		4							4
Worcester.....		1			1	6			8
Total.....	78	264	8	19	26	111	67	188	761

M—Medical service, over 15 years of age.

P—Pediatric service, under 15 years of age.

TABLE II
Clinical Classification of Patients

	NON-PARALYTIC		SPINAL PARALYTIC		BULBAR		TOTAL
	No.	Per cent	No.	Per cent	No.	Per cent	
1950	92	27	201	59	49	14	342
1951	10	37	14	52	3	11	27
1952	36	26	77	56	24	18	137
1953	76	30	120	47	59	23	255
Total...	214	28	412	54	135	18	761

TABLE III
Age Distribution of Patients in 1950 and 1953

	1950		1953	
	No.	% of total	No.	% of total
Under 1 yr.....	12	3.5	6	2.4
1-4.....	83	24.2	74	29.1
5-9.....	120	35.1	75	29.4
10-14.....	49	14.4	33	12.8
Over 15.....	78	22.8	67	26.3

brospinal fluid abnormalities. The following data was obtained in a group of patients and their contacts studied in 1952.⁴ Type I virus was the predominant, if not the only, infecting agent as judged from stool isolations, blood isolations and serological studies. Of 29 contacts of cases of paralytic poliomyelitis, ten converted from no antibody level to a significant titer and only seven had no evidence of type I antibodies in two bleedings one month apart. This is in contrast to 30 "non-paralytic poliomyelitis" cases and contacts in whom there was only one converter and 18 who showed no antibody titer in two weeks. It seems likely additional patients could be removed from the diagnostic classification of poliomyelitis if detailed virological studies become available on a wide scale in the near future.

The bulbar category includes those patients

⁴ Unpublished data obtained in collaboration with Dr. David Bodian, Johns Hopkins University School of Hygiene and Public Health, who applied the tissue culture neutralizing antibody techniques as well as performing the viral isolation studies mentioned.

who had both bulbar and spinal involvement. It is readily seen from the table that the percentage of patients with bulbar manifestations can vary over a wide range. This is particularly important inasmuch as the most severely ill patients fall in this class.

AGE DISTRIBUTION

Table III shows the age distribution of patients who were hospitalized in 1950 and 1953. Similar distributions prevailed in the other years that were studied. In the four year period ages ranged from four months to 65 years.

MANAGEMENT OF Milder FORMS OF THE DISEASE

In those patients whose life is not threatened by bulbar or respiratory muscle paralysis, the management is directed toward relief of symptoms, accurate periodic re-appraisal of the extent of involvement, control of metabolic derangements, and support of the morale.

Urinary retention is not uncommon in lower spinal involvement. In children the parasympatheticomimetic drug, furmethide[®], was found useful in doses of one to six mgm. Occasionally catheterization was necessary, particularly in the older patients. Constipation was frequently encountered and treated with enemas. Painful muscles from hyperextension and "spasm" were aided in some instances by moist heat applications, at times with analgesics, and occasionally with splints. Patients with mild pharyngeal muscle paralysis were adequately managed by mechanical suctioning of oropharyngeal secretion plus proper guidance of oral intake.

Physical therapists valuably assisted the medical staff in assessing muscle involvement and, thus, in the decision for ultimate disposition. Little physical therapy as such, was carried out during the early acute stage, but in the more severe cases and in those where a complication prolonged the stay, the avoidance of contractions and early re-education of the patients in muscle use were stressed.

TABLE IV
Deaths and Case Fatality Rates

YEAR	AGES										TOTAL	
	Under 1 yr.		1-4 yrs.		5-9 yrs.		10-14 yrs.		15 yrs. & over			
	Deaths	% Mor-tality	Deaths	% Mor-tality	Deaths	% Mor-tality	Deaths	% Mor-tality	Deaths	% Mor-tality	Deaths	% Mor-tality
1950	1	8	0	0	2	2	0	0	5	6	8	2.4
1951	0	0	0	0	0	0	0	0	0	0	0	0
1952	0	0	0	0	1	3	0	0	3	12	4	2.9
1953	0	0	1	1	3	4	3	9	6	9	13	5.1
Total.....	Under 15: 11 deaths, 2% mortality								14	8	25	3.3

In patients in whom there was extensive paralysis of three or four extremities attention was given to the problem of calcium balance. At present such studies remain in the field of clinical and biochemical investigation, but hypercalcuria and early osteoporosis can be detected during the subacute stages of the illness.

Psychological factors appear of great importance in the moderately ill patients with poliomyelitis. Limited personnel, under the conditions of a large outbreak, restrict the scope of aid that can be accomplished. Volunteer groups were helpful in this respect at times.

MANAGEMENT OF SEVERE FORMS OF THE DISEASE

The patients with extensive bulbar involvement, paralysis of the muscles of breathing, or a combination of these are the most severely ill. Either a tracheotomy, a mechanical respirator, or both is generally needed in their management. In 1953 there were a total of 23 tracheotomies performed, 17 in adults and 6 in children. This procedure was felt to be especially indicated in those patients in whom an adequate airway could not be maintained otherwise, either because of weakness of the pharyngeal musculature and depression of the cough reflex or increasing stupor with subsequent aspiration of pharyngeal and buccal secretions. Each patient on whom a tracheotomy was performed thereafter required constant nursing vigil with emphasis placed on keeping the tracheotomy tube

clean and free of secretions and on prevention of infections of the tracheotomy wound. Antibiotics were used in the prophylaxis of pneumonia, tracheitis, and mediastinitis. Effort was also made, at least initially, to provide an atmosphere of high humidity to minimize the occurrence of viscid secretions.

In 1953 twelve pediatric and sixteen adult patients were placed in tank respirators. Nurses were constantly in attendance to ensure the continuous operation of the respirators under specified conditions and to help prevent such complications as hypostatic pneumonia and decubitus ulcers. All the adults placed in respirators received a tracheotomy to facilitate their subsequent nursing care. Many respirator patients were initially maintained on parenteral fluids and attention was directed at maintaining their electrolyte balance and assessing the respiratory acidosis and alkalosis so frequently occurring in such patients. Aspiration pneumonia is a common and often troublesome complication. In fulminant cases it may appear very early and play an important role in the mortality.

TABLE V
Disposition of Surviving Patients 1953

	HOME		ORTHOPEDIC HOSPITALS	
	No.	%	No.	%
Medical Service.....	32	51	31	49
Pediatric Service.....	94	52	87	48
Total.....	126	52	118	48

MORTALITY

In Table IV are given the deaths and case fatalities occurring in each year at different age ranges. With one exception, all the patients who died had either bulbar or bulbo-spinal involvement. The one exception had complete respiratory muscle paralysis without bulbar manifestations. The overall mortality for the four year period was 3.2%.

DISPOSITION OF PATIENTS

Table V shows the disposition of surviving patients on both the Medical and Pediatric Services. Kernan's Hospital for Crippled Children and the Children's Hospital School received nearly all the patients who were not discharged

home. All patients transferred in respirators were received at the Respirator Center of the Children's Hospital School.

SUMMARY

During the past four years 761 patients with acute poliomyelitis were treated as in-patients at Baltimore City Hospitals. There have been marked fluctuations in annual case loads and variations in the proportion of case types. The overall mortality was 3.2%.

An analysis of the cases treated and a discussion of their management and disposition has been presented with emphasis on the role played by Baltimore City Hospitals in the overall community program.

Musculo-Skeletal Function in Rheumatoid Arthritis¹

ROBERT L. PRESTON, M.D.²

Rheumatoid arthritis is a systemic disease, the disabling manifestations of which are almost entirely localized to the musculo-skeletal system. Therefore, the preservation or the restoration of the functional capacity of the musculo-skeletal system is of vital importance in the management of patients with this disease. A broad treatment program is required which will control the systemic aspects of the pathology as well as the local manifestations of the disease in the musculo-

skeletal system. Now that effective therapy is available for the control of the systemic rheumatoid process, it can be expected that a patient who receives the benefit of carefully correlated medical-orthopedic treatment will have an extremely good chance of recovering without significant functional disability.

The measures which are used to prevent deformity and preserve musculo-skeletal function need not be complicated or highly technical if this treatment is started at the onset of the disease and is continued consistently, without interruption, throughout the entire active course. In most instances this treatment can be prescribed and supervised by the internist who is responsible for the systemic treatment. However, if the treatment of the musculo-skeletal lesions is neglected until fixed deformity has de-

¹ Presented before the Baltimore City Medical Society on October 16, 1953, Osler Hall, Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore, Maryland. Dr. Joseph J. Bunim, National Institutes of Health, Bethesda, also appeared on this program, and his paper will be published in a later issue.

² New York, N. Y. Associate Clinical Professor of Orthopedic Surgery Post-Graduate Medical School, New York University.

veloped or if this treatment is applied sporadically, permitting periodic regression in joint efficiency, treatment which is highly technical usually becomes necessary and even with the best of luck some residual impairment of function may persist after maximum rehabilitation has been achieved. If it is necessary for the internist to call for the assistance of the orthopedist in the management of the musculo-skeletal aspect of the pathology, it is imperative for the success of the combined treatment program that the two clinicians carefully synchronize their efforts.

In the following discussion of the management of the musculo-skeletal lesions of rheumatoid arthritis, it is to be understood that each patient is under the supervision of an internist and that he is receiving systemic treatment continuously.

The treatment for the control of the musculo-skeletal lesions can be divided into five phases, which are:

1. The precise evaluation of the condition of the musculo-skeletal system at the onset of treatment, with frequent re-evaluations for the detection of any change in functional deficiency.
2. The protection of the musculo-skeletal system from unphysiological trauma by the immobilization of inflamed joints, the elimination of intra-articular and extra-articular causes of joint trauma and the control of the trauma to which the joints are exposed by protection from overuse.
3. The prevention of deformity.
4. The restoration of function.
5. The maintenance of function by the restoration of accurate muscular control and the use of protective apparatus when necessary.

In illustrating the practical application of each phase of this treatment program, the discussion will be limited to the management of lesions of the knee joint, which are the most common cause of crippling in rheumatoid arthritis.

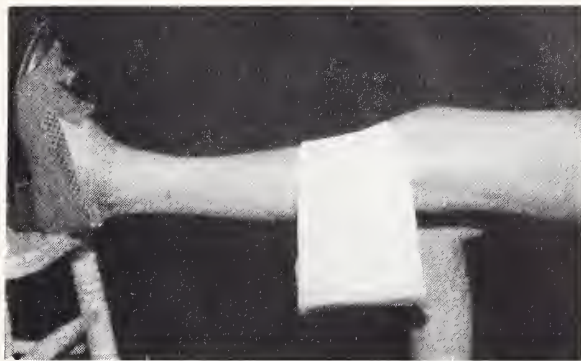


FIG. 1. Stretching the knee into hyperextension by the application of a weight of five pounds or more which is suspended from the leg, just below the knee. Effective stretching is accomplished with the use of relatively little weight if the treatment is continued without interruption for a half hour at a time. Quadriceps setting exercise is done while the knee is being stretched. Even after the range of passive extension is normal, the knee is immobilized in this manner during the quadriceps setting exercise, as this exercise is of no value unless it is performed with the knee at the limit of passive extension.

THE PREVENTION OF DEFORMITY AND THE TREATMENT OF THE SLIGHTLY DEFORMED JOINT

Let us consider first the patient with an early, low grade rheumatoid lesion of the knee which has not, as yet, produced significant functional impairment. Although there is mild limitation of motion which will need to be corrected, the principal problem is the prevention of deformity.

The treatment starts with a physical examination which includes a careful evaluation of all of the structures of the musculo-skeletal system. This examination is not limited to the knee as there may already be functional impairment of some of the other joints.

The signs and symptoms are those of any low grade irritation of the synovia of the knee; soreness when beginning to walk after prolonged rest, especially on arising in the morning, soreness on full motions or on prolonged use, excessive fatigue of the musculature of the thigh and leg, muscular atrophy, tenderness, swelling of the knee, slight limitation of active motion and slight limitation of passive motion.

We have, therefore:

1. A knee which is the site of a low grade inflammation for which rest and protection from trauma is indicated, and
2. A knee which can be held only in flexed position by reason of the loss of efficiency of the extensor muscles and the resistance to full passive extension, and
3. A knee in which the flexion deformity can be expected to increase unless measures are applied to make it possible for the patient to hold it firmly in the normal weight-bearing position of full extension.

In the presence of signs of inflammation, however slight, complete rest is indicated. The findings on physical examination determine the kind and amount of protection which is required at the onset of treatment. Most commonly, a cast is applied for a week or two and crutches are used to eliminate all weight-bearing. However, if the inflammation is very slight, motion can be permitted and the crutches used without the cast. If a cast is applied it must extend far enough proximally and distally from the knee to actually stop motion. The cast is applied with the knee at the maximum limit of extension.

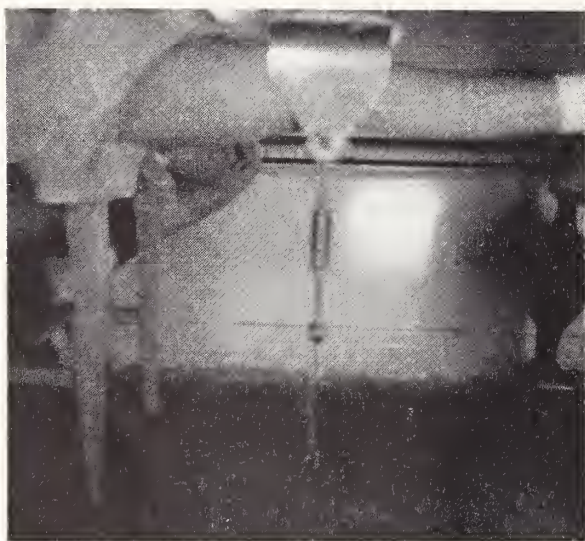


FIG. 2. A positive pressure apparatus which can be used for passive stretching of the knee, if stretching with a weight does not restore complete extension.

The Restoration of Active Muscular Control of the Joint

As weight bearing cannot be resumed until the patient is able to hold the knee firmly locked in the functional position of full extension by active muscular power, corrective exercises for the quadriceps muscle are started immediately. If the knee is immobilized in a cast, muscle setting quadriceps exercise is performed until the case is removed. Patients with rheumatoid arthritis usually are chronically fatigued and they have little stamina. For this reason, their exercise regimen usually must be reduced to the basic essentials. Until the patient is able to lock the knee firmly in functional position, the exercises are limited to those which will contribute to the ability to extend the knee through the last 20 degrees. As fatigue develops after only a few minutes of exercise, the daily dose usually is broken up into a number of brief sessions. As soon as sufficient muscular skill has been developed to enable the patient to bring the knee actively into maximum extension, passive resistance exercises are added to the program so as to build up the strength of the extensor muscles more rapidly. The exercises are continued until normal strength and endurance have been restored.

The Restoration of Passive Motion

Treatment for the restoration of complete passive extension is started as soon as the cast is removed. Until the knee falls loosely into the position of full extension, no effort is made to restore the full range of flexion, as complete extension is essential for function but satisfactory function can be accomplished without complete flexion.

These mild flexion deformities usually can be overcome by gentle passive stretching. The patient sits on a firm chair with the foot on another chair and a ten pound weight is suspended from the leg, just below the knee, for the purpose of producing a hyperextension force. The knee is

stretched for a half hour, three times a day. During the stretching, quadriceps setting exercise is done.

If this technic is not effective, a positive pressure apparatus can be applied. In using this apparatus the patient sits in the same posture and places a sling over the front of the leg just below the knee. The sling is then pulled firmly toward the floor by means of a turnbuckle or a rope which passes through an eyelet in the floor. A strong, steady hyperextension force is produced.

In some instances it is desirable to apply traction or a posterior splint to maintain full extension when the patient is at rest in bed.

If the full range of passive extension is not restored within a few weeks, the operative treatment which is used for the correction of fixed contractures is applied without further delay, as it is essential that complete correction of the deformity be accomplished.

Flexion to just beyond the right angle is essential, as this range of flexion is necessary to enable the patient to get up from a chair with ease. If the pathological changes in the knee are slight, a normal range of flexion usually should be restored but if the knee is severely disabled, no effort should be made to restore more flexion than the basic functional essential.

If the range is markedly limited, the patient sits on the side of the table and suspends a weight from the front of his ankle, so as to produce a strong flexion strain on the knee. If the knee can be flexed to at least 135 degrees but not beyond 90 degrees, he sits on a chair with his toe against a firm object, such as the leg of a table, and slowly slides the chair forward, in such a way as to produce a flexion strain on the knee. Or, if the knee can be flexed to at least 90 degrees, he lies on his back on a firm surface, places a sling around the front of the ankle and pulls firmly on this sling to produce the flexion strain.

After the full range of passive extension and the maximum range of passive flexion have been



FIG. 3. Improved traction apparatus which has been constructed with materials available in the home.

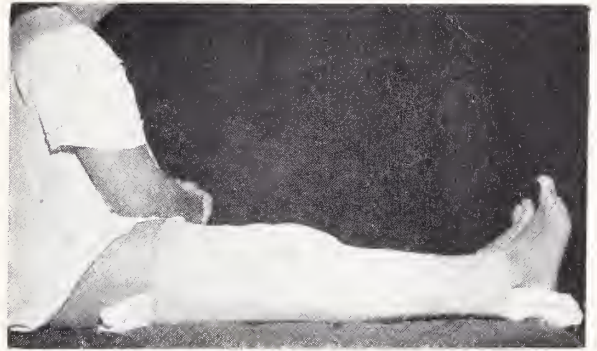


FIG. 4. Posterior splint to maintain full extension while the patient is at rest in bed at night. It should be noted that for effective control of the knee, the splint must extend from the hip to the foot.

developed, the stretching treatment is discontinued with the exception of five minutes of stretching which is continued each day for many weeks. At the first sign of loss of extension, the full therapeutic dose of stretching treatment is resumed.

The Cautious Resumption of Use of the Joint

As soon as the signs of inflammation have disappeared and the patient can extend the knee actively to the full limit, he begins to test the knee with use. The trauma to which the joint is subjected is very carefully controlled. A cane is used in the opposite hand for all weight-bearing and every step is carefully considered so as to insure relatively atraumatic function. All

arduous or complicated use is eliminated. If one knee is relatively normal, he uses this knee to lift himself up out of a chair and he goes up or down stairs one step at a time. As the efficiency of the musculature which controls the knee increases and it is demonstrated that use does not cause recurrence of disability, the activity is increased and the precautions against trauma are gradually relaxed. Careful physical examinations are made at frequent intervals so that the program can be adjusted promptly to accommodate for changing conditions.

THE MODIFICATION OF THE BASIC TREATMENT PROGRAM AS REQUIRED BY VARIATIONS IN THE PATHOLOGY

The basic treatment program has been described as it is applied to the low grade knee

joint lesion which has produced only mild inflammation, slight fixed deformity and slight muscular inefficiency. This basic program is modified to meet the conditions presented by variations in the pathology by placing more emphasis on one or another phase of the treatment. If the initial clinical study does not reveal definite signs of inflammation in or around the knee and the physical examination discloses only slight limitation of active and passive motion with only mild muscular atrophy and the patient complains of no more than mild soreness on excessive use, a cast or crutches need not be used but the patient must protect the joint from trauma and he must follow the same regimen as do the patients who are beginning ambulation after the subsidence of more severe knee joint inflammation. In the management of the acutely inflamed knee, the immobilization aspect of the treatment becomes of major importance during the period of active inflammation but after the subsidence of the inflammation, the program continues as has been outlined for the management of the more low grade lesions. And, in the treatment of the knee which is permanently contracted in deformed posture, the restoration of passive extension is the feature of major importance but once the deformity has been corrected, the program proceeds as has been outlined.

The correction of severe permanent flexion deformity of the knee presents special problems. Many operative procedures have been proposed for the restoration of passive extension to these knees, but after considerable experience with the various operations, the author has come to the conclusion that the best end-results are secured by the use of either manipulation under anaesthesia or open cutting of the restraining tissues, whichever is indicated. In general, closed manipulation is used for the correction of mild or moderately severe deformities of relatively recent origin without significant bony changes, and, open operation is used when the deformity is old and severe, when there are changes in the contours of the articular surfaces



FIG. 5. Case M. B. The patient attempting to stand prior to the operation. Although the right knee extends passively to 140 degrees, when she stands this knee is held at 110 degrees due to the extreme weakness of the extensor muscles.

or when manipulation fails to restore full extension.

THE USE OF CORTISONE OR ACTH AT THE TIME OF SURGERY

Since the introduction of cortisone and ACTH, the end-results of the surgical treatment of rheumatoid knees have improved significantly. Irrespective of the place which these hormones finally assume in the therapy for the control of rheumatoid arthritis, there is no question that they have supplied the surgeon with a therapeutic tool of primary importance. Clinical studies indicate that it is now feasible to do an operation which is extensive enough to correct all of the principal features of the pathology since there is reasonable assurance that the rheumatoid inflammation will be controlled, post-operative scar formation and edema will be inhibited and post-operative pain will be minimized. The feeling of well-being which frequently results from the use of cortisone or ACTH makes it easier for the patient to co-operate in the post-operative program which is necessary to complete the functional rehabilitation.

THE CORRECTION OF MODERATELY SEVERE DEFORMITY

The correction of knee joint deformities by manipulation under anaesthesia can be illustrated by the following report of a typical case. This 49 year old housewife (Case M. B. University Hospital #K23699), developed rheumatoid arthritis four years before she was admitted to the hospital. For about two and a half years prior to admission she had been unable to stand or walk because of the severe flexion deformities of both knees. The rheumatoid arthritis had remained moderately active since the onset.

The examination at the time of admission to the hospital revealed the condition of both knees to be approximately the same. There was moderate synovial effusion and marked synovial thickening. On palpation there was mild generalized tenderness which was most severe in the region of the fat pads on the anterior aspect of the

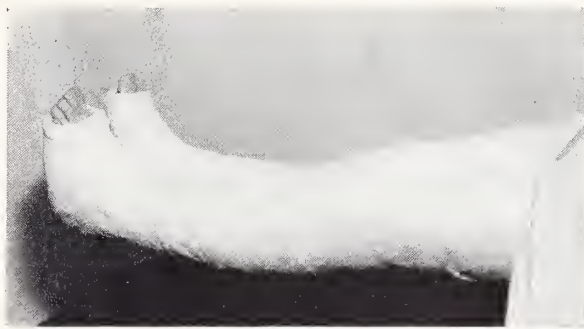


FIG. 6. Case M. B. The post-operative casts which were applied with the knees in complete extension, the ankles in dorsi-flexion and the feet in weight-bearing position. It should be noted that a cast for the immobilization of the knee must be long enough to extend from the groin to the ankle or the tip of the toes.

knees. Passive extension was limited by 40 degrees. There was only slight pain at the extreme of this motion. The range of active extension was 15 degrees less than the range of passive extension. Active and passive flexion was normal and there was only slight pain at the extreme of flexion. There was no crepitation, irregularity in motion or clicking on motion of the knees. Marked lateral and anterior-posterior instability was present in both knees. The musculature of the thighs and calves was markedly atrophic.

The X-rays of the knees revealed severe osteoporosis. The contours of the articular surfaces were normal with the exception of slight cuplike erosions of the central portion of the lateral plateau of the tibia on both sides, at the point of contact with the lateral condyle of the femur. There was no osteophyte formation. The bones were in normal relationship with each other.

The hips and the trunk had not been involved in the rheumatoid arthritis. The range of motion of the hips was approximately normal but the patient could bring these joints to the full limit of active hyperextension only with the greatest of effort and she could hold them in functional position only for an instant. The range of motion of the back was normal but the patient habitually sat in bed with a marked increase in the physiological curves of the spine and she could sit in erect posture only with difficulty. It was apparent that during the years of wheel-chair

existence she had lost the ability to control the trunk and hips and it was anticipated that she would have difficulty in stabilizing these joints when she became ambulatory.

The initial physical survey also revealed slight deformities in the feet, hands, and wrists which were not of functional significance and did not require treatment at that time.

From the time of admission to the hospital, the patient did corrective exercises for the musculature of the trunk and hips. These exercises were performed four times every day, with the exception of the few days after each operation. By concentrating on the reconditioning of these muscles during the first few weeks of the hospitalization, the skill and strength which was necessary for ambulation was restored promptly and this problem was disposed of before the start of the intensive exercise program for the knees.

On the day after admission to the hospital, both knees were manipulated under general anaesthesia. Only minimal force could be used and when the knees had been extended to 160 degrees, considerable resistance was encountered. In view of the extreme osteoporosis, it was decided not to attempt full correction at that time and to immobilize the knees at maximum extension. Casts were applied extending from the groin to the tip of the toes with the knees at 160 degrees, the ankles in full dorsi-flexion and the feet in weight-bearing position.

The post-operative reaction subsided rather slowly and it was twelve days before the involun-

tary muscle spasm stopped and the patient became free of pain. At that time the casts were cut at the knees and under general anaesthesia the knees were brought into 190 degrees of extension. The casts were repaired so as to immobilize the knees in this position.

After a week, the flexor muscles stopped contracting spontaneously and the casts were cut and the knees examined. Cautious motion did not stimulate spasm or significant pain so the casts were discarded and traction was applied to both legs. The traction was used whenever the patient was in bed during the remainder of the period of hospitalization. At first, the corrective exercises were limited to muscle setting of the quadriceps with the knees held in full extension. These exercises were performed six times a day and they were continued at each session to the point of moderate fatigue. After about a week, the quadriceps function having improved to the point at which it was possible for the patient to contract these muscles accurately on command, assisted quadriceps exercises were started.

The patient was not permitted to stand until she could hold the knees in the functional position of full extension. Ten days after the casts were removed she was permitted to stand, her weight being supported almost entirely by the attendants and the walker. She was not permitted to flex the knees on taking a step, as it is easier for a patient to keep the knees in weight-bearing position during the entire stride rather than struggling to extend the knee from the flexed position on every step. The stiff-leg ambulation was continued until about the time she left the hospital. The number of steps she was permitted to take was limited to those which could be accomplished with the knees held in proper position. Unlimited activity was not permitted until about ten months after operation.

She left the hospital approximately two months after admission. At that time she was able to stand on one foot, bearing all of her

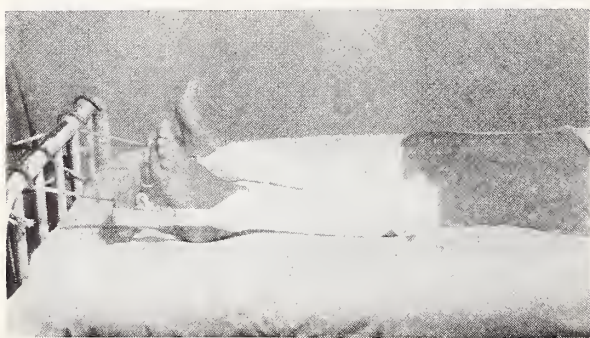


FIG. 7. Case M. B. Traction was used to maintain full correction of the flexion deformity whenever the patient was at rest in bed.

weight with the knee locked in full extension and the trunk and hip in functional position. It is not safe to discharge a patient from intensive observation until this degree of muscular efficiency has been attained. The use of traction while at rest in bed was discontinued at the time of discharge from the hospital as, by that time, the active control of the knees was so good that there seemed to be no danger of recurrence of deformity. In some cases, the traction must be continued for many months and in other cases in which the efficiency of the extensor muscles develops very slowly, braces must be worn for all ambulation for some time so as to prevent the knees from being used in deformed posture.

At the time of discharge from the hospital, knee flexion exercises and passive resistance exercises for the quadriceps muscles were started. At this time the exercise program also included free exercises for the trunk, hips and quadriceps. All of these exercises were performed to the point of definite fatigue three times a day. After six months, the trunk, hip and knee exercises were reduced to one session a day. At that time, hand, wrist, foot and ankle exercises were started. Two and a half years after discharge, she developed an exacerbation of the rheumatoid inflammation in the wrists and it was necessary for her to wear aluminum splints for six weeks. During the entire period of observation no exacerbations of inflammation occurred in any of the other joints. Three years after discharge from the hospital, the exercises for the left knee were discontinued and those for the right knee, the hips and trunk were discontinued a year later. It was recommended that the right foot, the hand and the wrist exercises be continued once a day for an indefinite period, due to the presence of irreversible deformities in these joints.

At the time of the last examination, four years after operation, there was a normal and painless range of active and passive motion in the back, hips and knees and there was no significant



FIG. 8. Case M. B. A walker was used to support most of her weight until the efficiency of the quadriceps muscles was restored.

abnormality in any of the other joints with the exception of the wrists, hands and the right foot.

This case report has been given in some detail as it illustrates the adaptation of the basic treatment program to the management of knee joint lesions which require surgical treatment for the restoration of complete passive extension. Of special interest is the long period of therapeutic exercise which was necessary in this case to stabilize the correction and ensure the maintenance of function.

THE CORRECTION OF SEVERE DEFORMITY

The correction of severe permanent flexion deformity of the knee which is complicated by severe damage to the extensor motor apparatus, extensive intra-articular adhesion formation, and marked irregularity in the contours of the articular surfaces requires extensive surgery in addition to the basic treatment program. If these joints are to function satisfactorily after

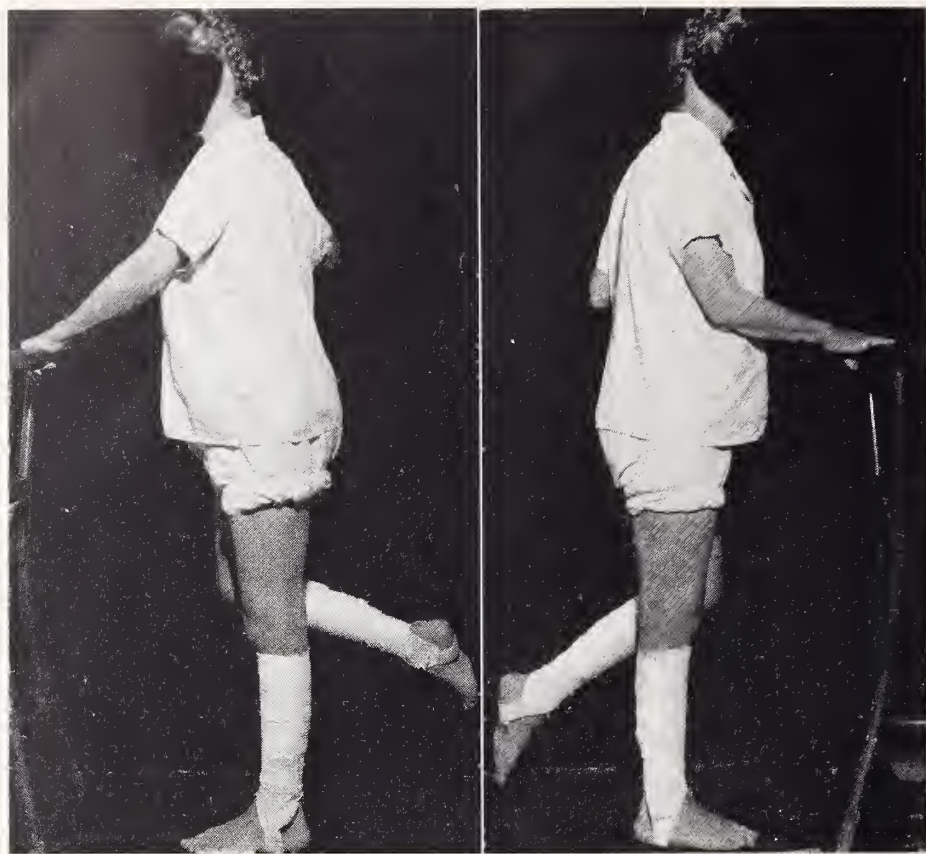


FIG. 9. Case M. B. Two months after operation. Standing with all of her weight on one foot with the knee, hip and trunk locked in functional position by active muscular power.

operation, the contracted tissues must be lengthened so that the knee can be brought into full passive extension, the physiological tension of the motor apparatus must be restored so that the joint can be moved skillfully into functional position by active muscular power, and the intra-articular causes of impaired active and passive motion in the anterior compartment must be eliminated.

Surgical Technic

For the correction of the flexion deformity, the posterior capsulotomy operation reported by Wilson (1), produces a more satisfactory result than the mere lengthening of the hamstring tendons. In this procedure the biceps femoris tendon and the fascia lata are lengthened and the posterior capsule of the knee joint and the periosteum of the posterior aspect of the lower fourth of the femur are stripped from the bone.

I have modified the technic so as to prevent post-operative lateral instability (2). This modification consists of stripping the periosteum from the posterior surface of the femur and then entering the posterior compartment of the joint from above, stripping only the posterior attachment of the capsule so as to avoid injury to the medial and lateral collateral ligaments.

The anterior compartment of the joint is then entered for the purpose of freeing the structures which must glide during joint motion. If the suprapatellar pouch or the joint cavity lateral, medial and distal to the patella are obliterated, the adhesions are cut and the intra-articular space is re-established. In order to ensure adequate room in the anterior compartment of the knee, most of the fat pad is excised. The irregularities on the articular surfaces and the osteophytes on the patella, femur and tibia are removed so as to avoid irritation of the soft

tissues which must move over the bones on motion of the knee. In some instances a considerable portion of the articular aspect of the patella is excised. Any areas of the synovial membrane which are definitely pathological also are excised.

If the patellar tendon and the quadriceps muscle have become too lax they are tightened by moving the tubercle of the tibia distally a distance of $\frac{1}{8}$ inch for every 10 degrees of flexion deformity (3).

The post-operative regimen includes immobilization in a cast for one week, with the knee in about 15 degrees of flexion to avoid overstretching of the popliteal artery. When the cast is removed, traction is applied to bring the knee into the fully corrected position. After the operation, these patients follow the same basic treatment program as do any other patients with knee joint disability of rheumatoid origin.

The Functional Results of the Surgical Reconstruction of Severely Deformed Knee Joints

The follow-up data is available on 18 knees of eleven patients upon whom the comprehensive reconstruction operation was done while the patient was under the influence of cortisone or ACTH. The irreversible pathological changes in all of these knees were severe and all of the patients were totally disabled prior to operation. Five of the patients had not been able to ambulate for some time and the remainder were using crutches. These patients have been observed for periods of six to twenty-four months since operation.

Arthrotomy of the anterior compartment of the knee was required in all of the cases. Posterior capsulotomy was not required for the correction of the deformity of five knees of three patients. The flexion deformity of these knees was slight, varying from 20 to 30 degrees, and when manipulation was attempted prior to making the incision for the posterior capsulotomy, it was discovered



FIG. 10. Double-bar brace with a Thomas ring at the upper end and a lock at the knee. This brace can be adjusted so that the weight is carried on the tuberosity of the ischium and the knee is relieved of all weight-bearing. The knee can be locked continuously in full extension or the lock can be released to permit flexion of the knee when the patient is seated.

TABLE I
The Correction of Severe Deformity of the Knee

Number of Patients.....	11
Unable to Walk Prior to Operation.....	5
Walked With Two Crutches Prior to Operation.....	6
Number of Knees Operated.....	18
Arthrotomy of Anterior Compartment.....	18
Posterior Capsulotomy.....	13
Deformity Corrected by Manipulation.....	5
Transplant of Tubercle of Tibia.....	7
End-Results (Follow-up Period—6-24 months)	
Satisfactory (82%).....	9
Unsatisfactory (18%).....	2

that the deformity could be corrected completely with the use of only mild force. It was necessary to displace the tubercle of the tibia on seven knees of four patients. In one of these cases, the tubercle was displaced at a later operation when it was discovered that the quadriceps could not be shortened sufficiently to lock the knee in full extension. With one exception, the knees which required the displacement of the tubercle were severely deformed, 50 to 80 degrees of fixed flexion being present.

Nine of the patients, or 82% had a satisfactory end-result; that is, they are able to do sufficient walking to engage in ordinary activities, with the knee held in functional position, without the development of pain and they are able to flex the knee sufficiently to climb stairs or to get up from a chair. Some of the patients in the successfully rehabilitated group use a cane for extensive walking but none of them use crutches. Five of the patients in this group have had persistent, mild to moderate rheumatoid activity throughout the entire period of observation.

Two of the patients had unsatisfactory end-results. The pathological changes in and around the knees of these patients were no more severe than those in some of the successfully rehabilitated patients. One of these patients developed intolerance to cortisone and the rheumatoid arthritis has remained persistently very active in many joints, including the knees. She has maintained a satisfactory range of active motion but the knees have been too painful for more than very limited walking. The poor end-result seems to be due entirely to the inability to control the systemic rheumatoid

arthritis. The other patient with an unsatisfactory end-result has pain only on extensive walking but she has practically no motion in the knees and there has been a 30% recurrence of flexion deformity in one of her knees. The systemic rheumatoid arthritis has remained moderately active throughout the entire period of observation but this has not seemed to be a significant factor in the end-result. The most important cause of the failure to rehabilitate this patient is a marked psychological instability which made it impossible to secure any co-operation with the post-operative muscular rehabilitation program which is essential in these cases.

SUMMARY

The basic regimen for the management of the musculo-skeletal lesions of rheumatoid arthritis has been presented and the details of the treatment described as it is applied to the early deformity, the moderately severe deformity and the lesion which has produced severe permanent deformity. All phases of this program are applied in the treatment of all of the musculo-skeletal lesions of rheumatic arthritis, the various aspects being modified as necessary to meet the conditions presented by variations in the pathology.

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NEW HEALTH COSTS IN BUDGET

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The Eisenhower budget calls for a slight reduction in overall health spending for the year starting next July 1, but adds \$7 million cash, plus \$82 million contract authority for the proposed reinsurance and clinic-nursing home programs. The regular Hill-Burton program would get \$50 million, Institutes of Health about the same as this year, and VA a 10% cut.

"Breast Self-Examination"

EDUCATIONAL AND CLINICAL EFFECTIVENESS OF THE FILM

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INTRODUCTION

The art of cancer education consists not alone in knowing the value of early diagnosis and treatment but also in imparting that knowledge to the public. Despite the interest in current cancer education, have we succeeded in partially dispelling the pall of public ignorance about this dire disease? Is the effort expended upon education adequate to arouse curiosity and stimulate interest in the common danger signals of breast cancer? Until the development of a specific and reliable test for cancer, "all of us must grow more and more alert to malignancy on less and less clinical evidence." For although the discovery of a small breast tumor which is presumably early in its development is no guarantee of curability, yet fact or chances favors this probability. There is nothing quite so simple as to believe only that which we wish to believe. However, does the record of our experience with public instruction indicate a genuine desire and popular willingness to practice the principles of cancer prophylaxis?

Recent estimates indicate that this year alone, out of every five thousand people in the average American community, there will be twelve new cases of cancer (*including two women with breast cancer*), seven people will die of cancer (*including one woman with breast cancer*), and two or three people with cancer will be "cured." Cancer incidence rates indicate that breast cancer in the female is by far the commonest single organ site of predilection. Current mortality statistics reveal that 4 per cent of all women reaching the age of thirty-five are

destined to die of breast cancer (1). Despite the fact that the breast is a readily accessible surface organ only two out of five cases of breast cancer will be discovered while the tumor is still localized to the breast alone. Almost two thousand years ago Celsus said that "only the beginnings of a cancer permit of a cure." Today the correlation between time of onset, size of tumor, stage of disease and ultimate prognosis is sufficiently well defined to justify our utmost effort in attaining the earliest possible diagnosis.

An excellent educational film in color and sound entitled, "Breast Self-Examination" has been produced in recent years by the collaborative efforts of the American Cancer Society and the National Cancer Institute. This cancer control motion picture teaches women the importance of examining their own breasts by a simple technique of inspection and palpation. The method is patterned after that which physicians are taught to employ and requires only a few minutes of time *practiced regularly once a month*. In sponsoring the routine health habit of breast self-examination the vital force of public education is carried across a significant threshold—it endeavors to make every *home* a cancer detection center. This investigation was undertaken with the specific purpose of evaluating the effectiveness of the film "Breast Self-Examination" in educating a large group of women who saw the film under standard conditions and similar circumstances.

METHODS AND MATERIAL

The film "Breast Self-Examination" is a 16 mm. sound film in color. In its preparation,

great care was taken to avoid frightening the women who would view it (2). An attempt was made to illustrate the technique of breast examination as practiced by a physician with emphasis on thoroughness and gentleness. The demonstration of the proper method of breast examination by the physician is followed by a portrayal of how a physician may teach a patient to examine her own breasts. The final emphasis of the film is on the hopefulness of early diagnosis. The overall aim of the presentation is to encourage monthly breast self-examination as a method of detecting curable breast cancer. The film was shown during April and May, 1952, over a four week period, to approximately 3100 (98%) female employees of The Bureau of Old-Age Survivors Insurance, Social Security Administration, Department of Health, Education, and Welfare in Baltimore, under the joint auspices of the Maryland Division, American Cancer Society and the Bureau. They viewed the film in small groups of thirty to fifty individuals and each showing was accompanied by a discussion led by a surgeon experienced in the handling of breast disease. Questions by the audience were encouraged in the discussions.

At the time of the showing of the film there was no plan to assay its effectiveness and no comment about this aspect of the program was made. Approximately six months after the showing of the film there were approximately 2400 female employees who had seen the film and were still employed by the agency. However, 2358 (98%) were actually interviewed. The color and age composition of these employees was approximately the same as that of adult females of the city of Baltimore. This similarity was particularly marked in the age groups 20 to 44. These 2358 women were individually interviewed by a questionnaire designed to test the effectiveness of the film on the number and frequency of breast self-examinations performed before and after film showing and by disease found. The questionnaire was further designed to test the effectiveness, as above indicated, in terms

of the background of the individuals, and for this purpose the individual's previous experience with breast abnormalities was considered, as well as the marital status, parity, color, age, and educational level. The specific points of the questionnaire will be brought out when the results are discussed below. In order to reduce the subjective error of the interrogator, five well-trained female interrogators were used. The questioning took place over a period of about two weeks during the month of November. In order to reduce possible subjective influences on the part of the interviewee, the questionnaire was anonymous.

To measure the validity of the answers in the questionnaire regarding frequency of examination, each individual was asked the last month of examination. This answer was then correlated with the number of times the interviewee reported self-examination. There was a remarkably good correlation between the number of examinations and the month which might be expected to have been the last month of examination. We have therefore assumed that there was a reasonably high degree of validity to the answers obtained. Other internal checks of reasonability of replies to particular questions were made. These proved the general validity of the information given by the women interviewed.

It must be pointed out that this particular report differs from others previously reported in two respects. First, a large representative population was available. Second, the film was accompanied by a physician-audience discussion.

EDUCATIONAL EFFECTIVENESS OF THE FILM-PHYSICIAN DISCUSSION COMBINATION TECHNIQUE

The principal gross effect of the film showing seems to be that 80.7 per cent of the 2,358 individuals interviewed examined their breasts occasionally or frequently after the film showing, compared with 7.8 per cent who did so prior to the showing of the film (Table I).

It is reasonable to assume that this remark-

able improvement in the rate of self-examination is solely the result of this health education technique. One might question, however, whether the high reaction ratio is explained in part by individuals who practiced self-examination only on a single, or at most, two or three occasions during the six-month period. In order to clarify this, each woman who had practiced self-examination after the film was asked the number of times she had examined herself since seeing the film. Some 590 or 31 per cent reported that they had examined themselves at least six times during the six months after the film. Another 5 per cent examined themselves as many as five times during the six-month period (Table II). One might, therefore, conclude that there remained a hard core of about one-third of the total who saw the film and practiced self-examination afterward, who were influenced to practice breast self-examination with some regularity during the approximate six month period intervening between learning the technique and time of interview.

It was thought that women who had previously had breast difficulties might be more responsive to the film. However, there seemed to be a greater response to the film among women who had had no previous abnormalities than among those who had. The survey indicated that 72 per cent of the women with previous abnormalities who had not practiced self-examination before the film reported that they began self-examinations after the film. On the other hand, about 80 per cent of the women without abnormalities who had not practiced self-examinations reported self-examinations started for the first time after the film.

It was interesting to note a significant difference in response by marital status. Two thirds of the women were or had been married. Of the married women who had previously not practiced self-examination, over 81 per cent did so after seeing the film. The comparable percentage for unmarried women was 74 per cent. Furthermore, a third of the married women who examined

TABLE I
Summary Data on Rate of Self-Examination before and after Film

SELF-EXAMINATION HABIT	BEFORE FILM		AFTER FILM	
	Number	Per cent	Number	Per cent
Total	2,358	100.0	2,358	100.0
Occasionally or frequently	184	7.8	1,902	80.7
Not at all	2,161	91.6	447	19.0
Not reported	13	0.6	9	0.3

TABLE II
Summary Data on Number of Self-Examinations after the Film

NUMBER OF EXAMINATIONS	ALL WOMEN		WOMEN WITH SELF-EXAMINATIONS	
	Number	Per cent	Number	Per cent
Total	2,358	100.0	1908	100.0
0 times	447	19.0	—	—
1 time	309	13.1	309	16.2
2 times	320	13.6	320	16.8
3 times	340	14.4	340	17.8
4 times	238	10.1	238	12.5
5 times	111	4.7	111	5.8
6 or more times	590	25.0	590	30.9
Not reported	3	0.1	—	—

themselves after the film did so at least six times during the six month period, as compared with a fourth of the unmarried women. Parity had no demonstrable effect.

Approximately three fourths of the women were white. There was a significant difference in the response to the film by white and non-white women. While only 76 per cent of the whites who hadn't done so before the film reported self-examinations after the film as much as 88 per cent of the non-white women reported examinations started for the first time after the film. Furthermore, while nearly 29 per cent of the white women reported six or more examinations, 38 per cent of the non-whites so reported.

The most striking finding appeared by age group (Table III). The response rate was highest for the youngest age group (84 per cent) and lowest for the oldest age group (62 per cent). This percentage continued to decline steadily from youngest to oldest age group with one exception, namely, for the age group 45-54. The

TABLE III
Effect of Film on Women, by Age Group

SELF-EXAMINATION HABIT	AGE GROUP													
	Total		Under 25 years		25-34 years		35-44 years		45-54 years		55 years & over		Unknown age	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Before film	2,358	100.0	410	100.0	963	100.0	601	100.0	274	100.0	100	100.0	10	100.0
Occasionally or frequently.....	184	7.8	17	4.1	67	7.0	58	9.7	28	10.2	13	13.0	1	10.0
Not at all.....	2,161	91.6	393	95.9	895	93.0	541	90.0	243	88.7	87	87.0	2	20.0
Unreported.....	13	0.6	0	0.0	1	0.0	2	0.3	3	1.0	0	0.0	7	70.0
After film	2,358	100.0	410	100.0	962	100.0	601	100.0	273	100.0	100	100.0	12	100.0
Occasionally or frequently.....	1,902	80.7	345	84.1	797	82.8	464	77.2	226	82.8	67	67.0	3	25.0
Not at all.....	447	19.0	65	15.9	165	17.2	137	22.8	47	17.2	33	33.0	0	0.0
Unreported.....	9	0.3	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	9	75.0
Rate of response to film ¹		80.0		83.5		81.5		74.8		80.5		62.1		—

¹ Calculated by dividing number without self-examinations before film into the number in this group with self-examinations after film.

substantial falling off in the practice of self-examination about the age of 55 years may mean that in the preparation of visual aids more care should be exercised in emphasizing the increased incidence of malignancy with advancing age. Perhaps greater care in the selection of subjects of appropriate age would be desirable or similar touchstones of cancer education might be specifically designed for this vulnerable age group.

The response to the film by educational background was measured by dividing the women into three groups as to whether they had less than high school education, high school education, and one year or more of college education (Table IV). Among those who had previously not practiced self-examination, those with college education and above showed the greatest response to the film. As much as 83 per cent of them reported self-examinations after the film. The response was slightly lower among high school graduates (80 per cent). Those with less than high school education responded less favorably (75 per cent) than the high school group.

CLINICAL EFFECTIVENESS OF THE FILM
“What did you learn from seeing the film,
‘Breast Self-Examination’?”

In answer to the direct question, “What did you learn from seeing the film, ‘Breast Self-Examination,’” the 2,358 women gave an aggregate of 4,407 separate responses, thus indicating several answers from many individuals. With this volley of replies (1.9 per person) we classified them initially into 32 categories and finally summarized them into four categories partly in accord with the recent study of Cohart and Hill (3).

	NUMBER	PER CENT
Total Replies	4,407	100.0
1. Nothing; very little	227	5.2
2. How to examine breasts; that self-examination is possible or easy	3,407	77.3
3. Importance of early detection and regular examination	503	11.4
4. Other answers	270	6.1
a. Favorable (188) 4.2 per cent		
b. Unfavorable (56) 1.3 per cent		
c. Indeterminate (26) 0.6 per cent		

TABLE IV
Effect of Film by Educational Level

EXAMINATION HABIT AND EDUCATIONAL LEVEL	BEFORE FILM		AFTER FILM		RATE OF RE- SPONSE TO FILM (PER CENT) ¹
	Num- ber	Per cent	Num- ber	Per cent	
Total.....	2,358	100.0	2,358	100.0	80.0
Occasionally or frequently....	184	7.8	1,902	80.7	
Not at all.....	2,161	91.6	447	19.0	
Not reported.....	13	0.6	9	0.4	
Less than high school....	650	100.0	650	100.0	74.6
Occasionally or frequently....	56	8.6	506	77.8	
Not at all.....	592	91.1	143	22.0	
Not reported.....	2	0.3	1	0.2	
High school.....	1,301	100.0	1,301	100.0	79.9
Occasionally or frequently....	86	6.6	1,057	81.2	
Not at all.....	1,211	93.1	243	18.7	
Not reported.....	4	0.3	1	0.1	
One or more years of college.....	394	100.0	394	100.0	83.0
Occasionally or frequently....	42	10.7	334	84.8	
Not at all.....	352	89.3	60	15.2	
Unknown.....	13	100.0	13	100.0	
Occasionally or frequently....	0	0.0	5	38.5	
Not at all.....	6	46.2	1	7.7	
Not reported.....	7	53.8	7	53.8	

¹ Calculated by dividing number without self-examination before film into number in this group with self-examinations after film.

The results of this inquiry reveal a favorable reply (under 2, 3 and 4-a) in 4,098 instances, or 93 per cent, thus indicating that the seeds of learning have been successfully sown. Unfavorable replies (under 1 and 4-b) total 283 answers, or 6.4 per cent, and indicate learning's labor lost.

"Did you find anything abnormal when you examined your breasts?"

In answer to this question there were 58 women out of the 1,902 who examined themselves after the film or 3 per cent who indicated that they had found an abnormality within their breasts; there were 1,844 women who had not found an abnormality. Almost two-thirds

of those women indicating the presence of a breast abnormality were in the 25-44 age group. It is of particular interest to note that of the 58 women who discovered an abnormality upon examining their breasts only 41 were sufficiently aroused to consult their doctor. However, in evaluating the significance of these answers one must bear in mind the semantics of the word "abnormal" in this question. It seems safe to suggest that probably the meaning of the word "abnormal" was not similarly interpreted by all interrogees. Lack of self-confidence in self-examination may also account for the failure to discover or report so few actual abnormalities. The incidence of breast abnormalities in so-called "normal" breasts has been variously estimated to be between 5 and 35 per cent depending upon whether the examination has been clinical or pathological (4) (5). Perhaps those women who were uncertain about an abnormal finding visited their physician for confirmation or reassurance. Since most lesions were considered innocent these women probably forgot the matter or were reluctant to admit their finding of a doubtful abnormality.

"Have you had a breast examination, by a doctor, since seeing the film?"

In answer to this question 569 or 24.2 per cent of the 2,358 women interviewed indicated that they had had a breast examination by a doctor since seeing the film; the remaining three-fourths said they had not had a physician's examination. Women in the higher work grades, older ages, and higher academic levels indicated a greater frequency of breast examination by a doctor since seeing the film. There appeared to be no discernible difference between whites and non-whites. Only 14 per cent of the unmarried women had had a breast examination by a physician whereas 28 per cent of the married women were examined.

Despite the fact that only 58 women noted a breast abnormality during their own examina-

tion, yet 569 women went to their doctor for a more thorough examination of their breasts. This breast examination was either incidental to a general examination or made specifically for this purpose alone. Greater confidence in a professional examination as compared to self-examination may partly explain this situation. However, the differentiation of a "lump" from a "lumpy" breast is often a difficult matter and may be beyond the ability to distinguish on the part of many women who perform self-examination.

Cancer education is frequently held responsible for creating cancerphobia. Yet in the matter of cancer detection a provident fear may be the mother of early diagnosis and later salvation. A good idea can't be blamed for the folly of its followers. The fact that 569 women were examined by their doctor some time during the six month period since being exposed to the film—physician discussion experience reflects a real appreciation and willingness to profit from the recommended advice.

In those 569 women who were examined by their doctor the answers to the subordinate question, "What did the doctor say?" varied considerably. However, most of the women (81 per cent) were found by the physicians to have no significant breast abnormality and were thus reassured. Some evidence of breast disease was noted in 52 women or 8.8 per cent and, as indicated by the response to the next question, a much smaller number came to surgery. The other 10 per cent gave miscellaneous and varying types of answers.

"Have you had a breast operation since seeing the film?"

In the six month period between seeing the film and replying to this question, 15 women were operated upon for breast disease by a surgeon of their own choice. The pathologic diagnosis was carefully investigated and confirmed as benign in each case. It is of special interest to note that prior to seeing this film only 110

women had ever had a breast operation over a cumulative period of many years, whereas within the six month period, since seeing the film, 15 women had already undergone surgery. Cancer education, therefore, results in a situation that places an enormous responsibility upon the cancer detection diagnostic skill and vigilance of every practitioner. Biopsy and surgical excision of discrete and solitary breast tumors is certainly the treatment of choice, yet great care and caution must be exercised to prevent needless surgery.

In addition to these 15 women who were present for both the showing of the film and the follow-up interview, three women who saw the film, but were not available for the interview, were subsequently operated upon for breast cancer. It must be pointed out that the three cases mentioned represent a minimum number of such cases, since there was no knowledge of the status of some 500 to 600 others who saw the film but were not available for interview. These three women who saw the film, but were not interviewed, were subsequently operated upon for breast cancer and were unable to be present at the time of the interview because of convalescence (two cases) and death (one case). While these three women who saw the film were not interviewed, it is known that they discovered their cancer as a result of self-examination, and the data about them are deliberately included because of their great bearing on the subject. Furthermore, if biostatistics is "arithmetic guided by logic," then the virtue of this deliberate inclusion of selected cases would be acceptable in the minds of both clinicians and biostatisticians.

In evaluating the armor of cancer education and more specifically the film "Breast Self-Examination" and associated physician discussion technique, do the results justify the means? Is there danger of creating cancerphobia by this "self-examination" habit? In the light of this consideration it is of paramount importance to note that the expected incidence of breast

cancer in this entire group of women over a six month period would be only *one* case of cancer of the breast, whereas, the actual incidence of breast cancer was at least *three* cases of this malignancy—three times the predicted incidence. A statistical test was made and it was found that the difference was highly significant. This three-fold increase in incidence will perhaps be still greater in the future, for this group of women have been alerted to the problem and are continuing the self-examination practice. Self-examination discovers those small and presumably early cancers which cast their shadows before them. Thus, although breast self-examination is by no means a divining rod, yet by its routine practice women are finding today what would be obvious tomorrow.

"Have you told any member of your family or any of your friends to examine their own breasts?"

In answer to this question there were 1,406 women or 60 per cent who replied "yes" and there were 952 women or 40 per cent who replied "no." From the nature of the study it is impossible to measure the cumulative benefits of this type of secondary spread of information.

SUMMARY AND CONCLUSIONS

1. A group of 2,358 women were personally interviewed approximately six months after seeing the film, "Breast Self-Examination" and participating in an educational discussion with a physician, to evaluate the effectiveness of this form of cancer education. The color and age characteristics of this group approximated those of adult females in the large urban community in which they live. A close correlation existed in answer to specific questions designed to test the validity of the results.

2. Prior to seeing the film only 7.8 per cent of these women indicated that they examined their breasts, whereas since seeing the film 80.7 per cent of these women or 1900 examined their breasts occasionally or frequently. About 33 per cent of the 1900 women who practiced breast

self-examination did so on a regular monthly basis as recommended by the film.

3. Women with a previous history of breast disease were less responsive to the film than the group at large. Married women, non-white women, and women with highest educational attainment responded best to this health education technique. The largest difference was between white and non-white and more markedly in groups whose ages were under 25 and over 55. The largest significant response due to educational background was demonstrated in the improvement between high school and less than high school education.

4. Indoctrination in the principles and practice of self-examination was highest in early adult life and lowest later in life. At about the age of 55 when the frequency of breast cancer is maximum, there appeared to be less effectiveness of the technique as manifested by less interest in the health habit of self-examination.

5. The importance of early detection and regular examination as well as the technique of breast self-examination were the most valuable lessons learned by this group of women. Only about 6 per cent of the replies indicated learning's labor lost.

6. Fifty-eight women or 3 per cent of those who examined themselves discovered an abnormality upon examining their own breasts. However, 569 or 24 per cent of these women who were interviewed went to their doctor for a more thorough examination of their breasts.

7. Prior to the showing of the film only 110 of the 2,358 women in this group had ever had a breast operation. After the film, in the short period of six months, there were 15 women, upon examination by a physician, who were deemed to warrant operation. Fortunately pathological examination showed these to be benign.

8. At least three women who saw the film, but were not interviewed, were operated upon and cancer of the breast proven. This is three times greater than the expected incidence of breast

cancer for this group of women over this period of time.

9. In the treatment of breast cancer the concept of early diagnosis and surgical therapy is a sovereign precept which affords the highest hope of greatest benefit. The technique of showing the film "Breast Self-Examination" with associated physician-audience discussions is an effective method of teaching the public the principles of early detection by means of self-examination.

The authors acknowledge with thanks the assistance of Dr. Harry L. Chant and K. Ruth Seese.

1900 St. Paul Street, Baltimore 18, Maryland

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NEW SENATE LEGISLATION

Senate Bill 2759 AMENDS VOCATIONAL REHABILITATION ACT

AMA Washington Letter—No. 56

An Administration bill based on the President's health message to Congress. The bill would substitute for the existing Vocational Rehabilitation Act a new act authorizing appropriations to assist in the rehabilitation of handicapped persons in three ways: (1) Grants to states to meet the cost of rehabilitation services, (2) Six-year grants to states to extend and improve rehabilitation services, and (3) Grants to states and to public and other non-profit organizations and agencies to meet the cost of unique projects directed toward the solution of regional or national rehabilitation problems. During the fiscal years 1955 and 1956 special project grants would be available for helping the states to plan and initiate a substantial expansion of their vocational rehabilitation programs.

The bill is not intended to provide grants for major new construction.

Each state would have a minimum allotment for general grants of \$50,000 with the federal share varying from 33 $\frac{1}{3}$ % to 66 $\frac{2}{3}$ %.

Extension and improvement grants would carry a minimum allotment of \$5,000 per state with the federal share up to 75% of the cost for the first two years, 50% for the next two, and 25% for the last two years.

Payments under the unique project grants would be determined by the Secretary of Health, Education, and Welfare. To receive federal approval of a plan, a state would designate a single administering agency and provide for personnel and administration standards to be approved by the Secretary of HEW. The state agency would agree to cooperate with the Bureau of Old-Age and Survivors Insurance, the state agency administering the state's public assistance program, and other bureaus providing vocational rehabilitation services.

Because of the new allotment and matching formulas, there would be a limit of 10% for any decrease in allotments to a state in any one year.

These amendments would become effective July 1, 1954. To Labor and Public Welfare Committee.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

At the annual election of the Medical Staff of the Cumberland Hospitals, the following physicians were elected to office:

Sacred Heart Hospital

President: DR. JAMES T. JOHNSON, JR.

Vice-President: DR. LEWIS BRINGS

Secretary: DR. JAMES P. HALLINAN

Memorial Hospital

President: DR. DONALD B. GROVE

Vice-President: DR. H. W. ELIASON

Secretary-Treasurer: DR. FRANK T. CAWLEY

BALTIMORE CITY MEDICAL SOCIETY COMMITTEES

CONRAD ACTON, M.D., *Journal Representative*

Dr Lewis P. Gundry, the President, has appointed the following Committees for 1954:

ADVISORY COUNCIL TO THE WOMAN'S AUXILIARY:

J. Arthur York, Chairman, Newland E. Day, Edward S. Johnson, J. Frank Supplee, III.

CONSTITUTION AND BY-LAWS COMMITTEE:

Moses Paulson, Chairman, Marius P. Johnson, Lawrence R. Wharton.

COMMITTEE ON EMERGENCY MEDICAL CALLS:

Paul E. Carliner, Chairman, James D. Carr, Joseph F. Drenga, Clewell Howell, Walter E. Karfgin, Lauriston L. Keown, Louis F. Klimes, Nathan Racusin, C. Arthur Rossberg, Aaron C. Sollod.

COMMITTEE ON GERIATRICS:

Herman Seidel, Chairman, Perry Futterman, Robert L. Jackson, Harry F. Klinefelter, Jr., Louis Krause, Robert E. Reiter.

LEGISLATIVE COMMITTEE:

Daniel J. Pessagno, Chairman, Raymond F. Helfrich, James P. Miller, Eduard Novak.

JOINT COMMITTEE ON MATERNAL MORTALITY:

Huntington Williams, Chairman, George H. Davis, D. McClelland Dixon, Louis H. Douglass, Nicholson J. Eastman, W. Drummond Eaton, John M. Haws, Hugh B. McNally, John E. Savage, Isadore A. Siegel, Matthew L. Taback.

MEMBERSHIP COMMITTEE:

William L. Garlick, Chairman, Maurice L. Adams, Joseph S. Ardinger, Jr., James G. Arnold, Dudley C. Babb, Benjamin M. Baker, Jr., Daniel E. Bogorad, Harry C. Bowie, Thomas S. Bowyer, Charles B. Brack, Charles E. Carr, Jr., Dwight M. Currie, Walter E. Dandy, Jr., Garrett E. Deane, John S. Eastland, Samuel L. Fox, Charles R. Goldsborough, S. Butler Grimes, Rachel K. Gundry, Louis P. Hamburger, Jr., Richard P. Hanchett, Robert W. Johnson, III, John M. Scott, Henry F. Ullrich.

POSTGRADUATE COMMITTEE:

Harry M. Robinson, Jr., Chairman, Samuel P. Asper, Henry T. Bahnson, Howard M. Bubert, C. Lockard Conley, J. L. Lilienthal, Ross L. McLean, Samuel Whitehouse, Wetherbee Fort, ex officio.

PUBLICITY COMMITTEE:

James R. Karns, Chairman, Conrad Acton, Barbara J. Betz, Ernest C. Brown, Jr., Ernest I. Cornbrooks, Jr., James D. Lockard, Harry M. Robinson, Jr.

COMMITTEE ON PUBLIC MEDICAL EDUCATION:

H. Hanford Hopkins, Chairman, Houston S. Everett, Whitmer B. Firor, Amos R. Koontz, Harry M. Robinson, Jr.

There are still a few committees to be appointed and they will be published in a later issue of the Journal.

The Postgraduate Courses have had a most auspicious start. At the first meeting more than sixty doctors attended. These courses interposed in the middle of the working day shows the interest that has been aroused. The continuing of professional education in our postgraduate years should be of growing concern to all of us. The burgeoning attendance at our meetings and these Courses make a very healthy index.

Our January meeting was very well attended and the program of "outside" experience in Tuberculosis gave perspective and fresh viewpoints. The Annual Meeting of the Faculty will be imminent when this

goes to press. We all wish the Auxiliary great success with its second annual Ball.

BALTIMORE COUNTY MEDICAL ASSOCIATION

SAMUEL P. SCALIA, M.D.

Journal Representative

The January luncheon meeting of the Baltimore County Medical Association was held at the Stafford Hotel on Wednesday, January 20, 1954.

The new officers and committee chairmen were introduced to the membership.

President, Martin E. Strobel; *Vice-President*, Thomas E. Wheeler; *Secretary and Treasurer*, Clarence E. McWilliams, Jr.; *Delegates and Alternates to the Medical-Chirurgical Faculty of Maryland*: Charles F. O'Donnell (*alt.*), Clewell Howell, Melvin B. Davis (*alt.*), David H. Andrew, George S. M. Kieffer (*alt.*), Samuel P. Scalia; *Legal Counsel*, William D. Wells; *Board of Governors*, Present Officers and Delegates, Past President:—Charles F. O'Donnell, William H. F. Warthen; *Board of Censors and Medical Ethics*, Charles F. O'Donnell, Charles H. Williams; *Medical Legislation*, Charles H. Williams; *Historical Committee*, Edward H. Benson; *Medical Economics*, George E. Urban; *Investment of Funds*, George S. M. Kieffer; *Hospital Committee*, Wilmer H. Gallager; *Public Relations and Journal Representative*, Samuel P. Scalia; *Publicity*, William H. F. Warthen; *Constitution and By-Laws*, William R. Dunton, Jr.; *American Medical Education Fund*, Paul H. Royse; *Emergency Medical Service*, Louis Dalmau.

It was announced by Dr. Strobel that the board of Governors had met on January 16, 1954 to discuss the proposed preliminary trial of Poliomyelitis vaccine. It was explained to the board by Dr. Edward Davens of the State Department of Health that this vaccine is definitely not the answer to the poliomyelitis problem and that a good deal of public-health education is necessary. The various organizations interested in this disease have been somewhat overzealous in their issuance of reports to the public. The preventive vaccine is not here and the proposed field trial is but a mass experiment. The vaccine has protected animals, but its use in humans has been very limited.

The directory of the Baltimore County Medical

Association was very successful in its first issue in 1953. A new edition is being prepared for 1954. All county practitioners are urged to contact Dr. Clewell Howell or Dr. Charles F. O'Donnell if they are not already listed in the 1953 directory.

The Baltimore County Health Department is conducting a survey of fatal home accidents. The cooperation of county physicians is being solicited. At the time of a fatal accident, a telephone call to the Health Department in Towson will suffice for a complete investigation.

As is customary, the outgoing president gave a short talk at the January meeting. Dr. O'Donnell brought out the fact that the Baltimore County Medical Association is now an integral part of health affairs in the county. The County Health Department confers with our society and this has made for better cooperation as concerns health matters in the county. This is important for it makes the organization the standard bearer of medicine in the county. Dr. O'Donnell also discussed the role of the county Medical Society in regard to Medical Care. The county plan is running quite smoothly and the county practitioners are to be thanked for their cooperation.

CARROLL COUNTY MEDICAL SOCIETY

WILLIAM L. STEWART, M.D.

Journal Representative

Two new members were received into the Society—Dr. Bertrand C. R. Gau, formerly of France and Dr. Howard Hall of Baltimore. Both doctors have recently established practices in Sykesville.

Officers for the coming year are: *President*, William Culwell; *Vice-President*, R. S. McVaugh; *Secretary and Treasurer*, William L. Stewart.

Dr. A. M. Powell of Frederick County, gave a very interesting and educational talk on "Therapeutic Poisons" as they are encountered in pediatrics when the Society met at Hoffman's Inn, Westminster.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

BENJAMIN S. MILLER, M.D.

Journal Representative

Dr. Samuel Sugar, Chairman of the Diabetes Detection Drive for Prince George's County, reported

a very successful campaign. Approximately 1600 tests were performed, of which 1350 were on students in the secondary schools. There were 91 positive results (two on known diabetics). This represents 89 potential new cases which were referred for evaluation to their family physicians. The Board of Education and two local chapters of the National Council of Jewish Women rendered outstanding aid in collecting specimens and conducting the tests.

At the January meeting of the Society, Dr. Norman Comeau spoke on "Sub-acute Thyroiditis." One of the cases reported represented the second case of this disease to be treated with cortisone.

WASHINGTON COUNTY MEDICAL SOCIETY

SIDNEY NOVENSTEIN, M.D.

Journal Representative

A winter meeting of the Washington County Medical Society was held at the Alexander Hotel with Dr. I. L. Houghton, retiring President, presiding.

New officers installed for 1954 were: *President*, Dr. Archie Robert Cohen; *Vice-President*, Dr. S. Earl Young; *Secretary-Treasurer*, Dr. Ernest F. Poole.

The question of public relations was discussed with reference to various articles in magazines and papers. Some of these articles were very critical of the medical profession. It was voted to approve the appointment of a public relations committee to take care of such adverse publications in the press.

The April meeting is to be devoted to the general

topic of public relations, the human side and the business side of medicine.

Dr. W. T. Layman is to represent the Society at the regional meeting wherein proposed legislation of the Eighty-third Congress is to be discussed.

Dr. Ross Cameron, Health Officer of Washington County spoke on the Medical Care Program, stating that he felt the Medical Care Program of Maryland is the answer to socialized medicine. The Advisory Committee of the Medical Care Program was invited to a meeting in Baltimore, January 19, 1954, at the request of the State Health Department.

Dr. David R. Brewer was the representative of the Washington County Medical Society at the regular meeting held in Washington, November 15, 1953, in reference to veteran medical care. The Society approved the request of the State Society that the three Veterans' Hospitals in Maryland be surveyed as to the percentage of service connected cases to non-service connected cases.

WICOMICO COUNTY MEDICAL SOCIETY

WILBER R. ELLIS, M.D.

Journal Representative

At the November 9th meeting of the Wicomico County Medical Society we were pleased to have as guest speaker Dr. Charles P. Bailey of the Bailey Thoracic Clinic in Philadelphia, who gave a most interesting talk on "Cardiac Surgery."

With us on December 14th was Dr. Byrd Leavell, Assistant Professor of Medicine, University of Virginia, who spoke on "Treatment of Anemias."

ON BEHALF OF ALLIED HEALTH PERSONNEL

AMA Special Report, No. 16

Quoted from a Statement of the American Medical Association To the Committee on Interstate and Foreign Commerce House of Representatives by Walter B. Martin, M.D.

Our most urgent effort should be directed to the solution of the problem of the medically indigent and the chronically ill. We believe that this objective can be reached without major change in our existing mechanism.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

MENINGITIS

LOUIS KRAUSE, M.D.*

Undoubtedly this disease is extremely ancient even though our literary remains fail to identify it as such. One of the fascinating references to the possible occurrence of a septic meningitis is found in the ancient Edwin Smith Egyptian surgical papyrus in which the attitudes of a patient are described. The fact was detailed that when the head is drawn backwards and held rigid, and the back becomes arched, the patient then must be kept at his "mooring post," the latter term meaning expectant treatment. It also relates that the condition may follow an injury to the head. Certainly this is a rather clear description of a meningitis secondary to a fractured skull, particularly of the base of the skull.

Throughout history, we have descriptions of symptoms that would suggest the possibility of meningitis. However, it is only recently that this entity has been clearly identified as we know it today. Such early terms as "spotted fever" because of the frequency of petechiae and "brain fever" because of the cranial symptoms, were generally used instead of the modern term of meningitis. With the advent of the bacteriological age, specific etiologic agents were identified and the clinical pictures of the various types of meningitis were readily supplied. This occurred at the turn of this century.

At first, therapy was directed entirely to the symptoms, and later to the mechanical changes in an attempt to reduce the intra-cranial pressure. Anti-sera were used. Today the antibiotics have been found to be very effective. Previously, in most instances, it was a devastating and fatal disease. Frequently those who survived became hopeless invalids, physically and mentally.

Today the picture has been entirely changed. Many times the disease is stopped in its tracks during its onset. The following list of books portray the

history, course, and effectiveness of present day therapy.

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* Chairman, Library Committee.

FIFTY YEARS AGO IN MARYLAND MEDICINE

Recently in connection with a research project in our library, we had occasion to consult the "Maryland Medical Journal" of 1904. We were fascinated by some of the material and, as this journal was the spiritual ancestor of the "Maryland State Medical Journal," we thought perhaps some of today's readers might be interested.

The big news at the beginning of the year was the Tuberculosis Exposition. The preliminary announcement reads:

"The Tuberculosis Exposition will open on January 25 at McCoy Hall. The opening meeting will be held at 8 o'clock on Monday evening. Prominent officials of the State and of the city will be present, including Governor Warfield and Mayor McLane. The orator of the evening will be Dr. E. L. Trudeau of Saranac, N. Y. At five o'clock each afternoon after Monday there will be lectures upon the various aspects of the tuberculosis problem. . . . The exposition is organized under the joint auspices of the Tuberculosis Commission, the State Board of Health, and the Maryland Public Health Association. These have called to their aid a large general committee of 250 leading citizens . . . the chairman, Dr. Henry Barton Jacobs."

Included in the executive committee were many names well-known in local medical history, among them Dr. W. G. MacCallum, Dr. William H. Welch, Dr. William Royal Stokes, Dr. Standish McCleary, Dr. S. J. Fort, Dr. Mary Sherwood, Miss Adelaide Nutting, and Dr. William Osler.

That the Exposition was a great success is shown in the issue of March 1904 which states:

"The Maryland Tuberculosis Exposition received the unstinted praise of discriminating observers from all parts of this country, and appears to have been duly appreciated inside the family circle of the State. Of those who watched the preparations no one doubted that the Exposition would reward the in-

terest of physicians and special students of tuberculosis, but many doubted whether its especial message would be effectively lodged in the public mind. When, within two days, the people had paid to the Exposition the amplest tribute of interest, its sponsors were gratified beyond measure. Even the most enthusiastic among them had not expected such success.

"... The Exposition demonstrated that it is both expedient and practicable to admit the general public to free participation in the scientific knowledge of tuberculosis, and the demonstration is highly important in a country where all reforms wait upon public opinion. It did not appear in this experiment that the education of the public is either difficult or dangerous."

February, of course, was the month of the Baltimore Fire and the editor of the "Maryland Medical Journal" has an editorial in the March issue which is something of a reproach today. We quote, in part,

"In the experience of a life-time hardly anything can be more impressive than the history of Baltimore in February 1904. A bewildering spectacle, an appalling disaster, and a magnificent opportunity were offered to us in the space of sixty hours. We accepted the opportunity with great enthusiasm and speedily convinced the world that a model city would arise upon the devastated area."

In the "medical items," the following note concerning the fire appears:

"One result of the fire has been an increased number of patients in the various hospitals, amounting in some instances to overcrowding. The amount of sickness is but slightly in excess of that which is usual at this season, but the number of persons seeking hospital treatment is largely increased."

A personal item of interest is the following:

"Dr. Hiram Woods is recovering from the serious accident which befell him in the collision of his carriage with a runaway team in Druid Hill Park."

M.E.B.

Health Departments

MARYLAND STATE DEPARTMENT OF HEALTH

Statement of the State Board of Health Regarding the Aims of the Proposed Preliminary Trial of Poliomyelitis Vaccine

In view of the increasing volume of publicity which has accompanied the proposed poliomyelitis vaccine field trial, the State Board of Health at its monthly meeting on January 15, 1954 expressed its concern that the real nature and purpose of this study shall not be obscured by wishful thinking. Some of the statements which have already appeared seem to have originated more from the imaginations of the overzealous than from the scientific facts at hand.

It should be clearly understood that as yet there is no scientific proof that this vaccine is effective in preventing polio in humans.

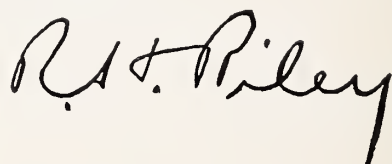
Medical history has clearly shown that important scientific advances have always come only after patient, painstaking, and objective work which is carried out with the utmost precautions to insure the accuracy of the study and the safety of the patient. There is no place in a study such as this for the overzealous enthusiast or the wishful thinker who jumps to the conclusion that a preventive vaccine is already here. In the words of Dr. Jonas Salk, the scientist who developed the vaccine which is now under study, "we do not want to allow any distortion of the fact that we are still actively in the stage of clinical investigation; and that this work must be continued, but it must be continued gradually and cautiously."

The State Board of Health and the public want, desperately want, to have an effective preventive vaccine available. The point is that if we are to achieve this happy goal we must be sensible and be guided by the most expert medical opinion available. The following statement has been prepared by outstanding poliomyelitis experts and represents the position of the State Board of Health at this time. It is planned that the statement will be revised when the scientific facts accumulated warrant such change.

For some years it has been apparent that the best hope for the control of polio lies in vaccination with the virus itself. More recently it has become clear that protection from paralysis can be produced in experimental animals by vaccines containing virus inactivated by chemicals—that is, virus incapable of causing disease. Preliminary trials of such vaccines in human beings indicate that they are harmless and that they produce immune responses which *should be* adequate to ward off paralysis. The proposed trials of vaccine are aimed at showing whether or not this is actually the case.

Paralytic polio is a relatively rare event even during epidemic times. For example, a severe epidemic of polio may strike down only one child in a thousand under ten years of age. This means that extensive trials in many thousands of children will be required before the protective power of a vaccine can be accurately determined.

Present supplies of vaccine probably do not allow of trials extensive enough to furnish a completely conclusive answer this year, but it is felt that the amounts which will be available this spring may give suggestive answers and will indicate the important lines to follow next year.



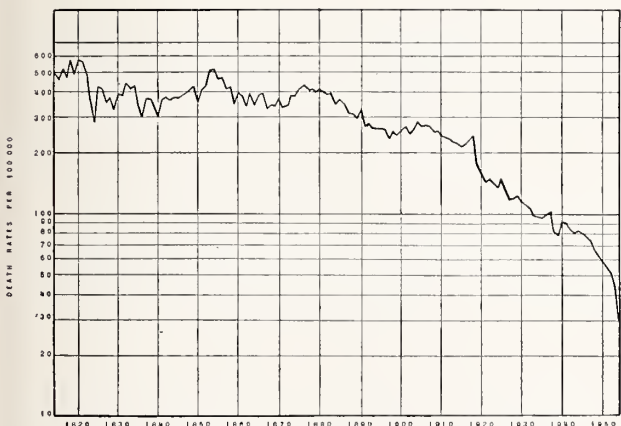
Director

BALTIMORE CITY HEALTH DEPARTMENT

Phenomenal Decline in Tuberculosis— 1953

A truly phenomenal decline of 31 per cent in Baltimore's tuberculosis death rate and an even more striking drop of 45 per cent in the city's Negro tuberculosis death rate compared with 1952 are the most prominent features in the vital statistics for 1953. With these health advances, tuberculosis for the first time in the medical history of the city drops out from the ranks of the "major killers."

From the very beginning of medical statistics pertaining to causes of death in Baltimore City, tuberculosis has ranked among the major killers. The earliest rate recorded, in 1812-1815, indicates that 525 persons per 100,000 died annually from tuberculosis. Following a variable course this rate dropped to 414, recorded in the period 1876-1880. From this point, tuberculosis has been slowly but steadily falling. In 1900 the mortality rate was 239; in 1920 it was 151; in 1930 the death rate from tuberculosis had declined to 115. The trend and rate of decline of tuberculosis mortality are shown in the following graph and table.



Tuberculosis Death Rates per 100,000 Population, Baltimore 1814-1953

DEATH RATES FROM TUBERCULOSIS (ALL FORMS)
BY RACE: BALTIMORE CITY 1940-1953

Year	Deaths per 100,000 population			Annual Percentage Change		
	Total	White	Colored	Total	White	Colored
1953	30.0*	19.0*	57.0*	-31	-21	-45
1952	43.5	24.0	104.1	-17	-18	-8
1951	52.1	29.3	123.9	-8	-10	-6
1950	56.4	32.5	132.6	-10	-4	-17
1949	63.0	33.8	159.8	-7	-12	-5
1948	67.8	38.3	168.2	-9	-4	-14
1947	74.5	39.9	196.0	-4	-11	0
1946	77.8	44.9	196.5	-4	0	-9
1945	80.9	44.8	215.0	-3	-3	-4
1944	83.1	46.4	223.7	+2	-6	+8
1943	81.1	49.2	207.7	-4	+5	-13
1942	84.2	46.7	240.1	-8	-3	-12
1941	91.2	47.9	271.4	-1	-10	+7
1940	92.1	53.2	253.0			

* Provisional rates.

From the table it is clear that there is no decline of more than 18 per cent compared with a prior year until 1953 when the white decline was 21 per cent and the nonwhite a precipitous 45 per cent.

The long time trend of decline has a variable interpretation. It is probable that the following factors have been important: Natural selection, by which is meant the process whereby those persons susceptible to tuberculosis have not reproduced to the same extent as persons resistant to the disease; improved standards of living and better habits of personal hygiene, together with an extension of better housing and a higher nutritional level to an ever widening segment of the population; and the effort of the Health Department in the control of tuberculosis by isolation of tuberculous persons as soon as possible after discovery and by careful observation and instruction of the contacts of such individuals. The recent acceleration in the decline of tuberculosis mortality is believed to be cumulative and also primarily due to the effectiveness of streptomycin and other related drugs. An analysis of newly reported Negro cases of tuberculosis in the last half of 1952 who were treated at home with streptomycin under supervision by the Bureau of Tuberculosis indicates that such patients have experienced a 47 per cent reduction in fatality rate as compared with a similar series of cases reported late in 1951 when the home treatment program had not yet begun.

Although the mortality from tuberculosis shows striking declines, the annual incidence of cases has remained fairly constant at about 1,400 for the past five years. This would appear to be somewhat unexpected in the face of the mortality trend except for the widespread use of mass X-ray surveys.

Huntington Williams, M.D.

Commissioner of Health

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT
Case Reports Received during 4-week Period, January 29–February 25, 1954

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARA- LYTIC	POLIOMYELITIS, NON PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County.....	65	1	3	4	158	—	84	—	—	—	32	—	—	3	20	—	7	—	5
Anne Arundel.....	21	—	—	4	24	2	18	1	—	—	2	—	—	—	5	—	4	—	10
Howard.....	1	—	—	—	9	1	5	—	—	—	1	—	—	1	1	—	1	—	—
Harford.....	15	—	1	32	1	—	25	—	—	—	19	—	—	13	4	—	—	—	5
Carroll.....	1	—	1	2	81	—	3	—	—	—	5	—	—	—	3	—	—	—	1
Frederick.....	—	—	—	10	3	1	—	—	—	—	2	—	—	—	9	—	1	—	4
Washington.....	10	—	—	13	—	1	16	—	—	—	—	—	—	5	7	—	1	—	2
Allegany.....	5	—	—	3	—	—	20	—	—	—	3	—	—	2	3	—	—	—	3
Garrett.....	—	—	—	14	1	—	—	—	—	—	18	—	—	—	—	—	—	—	1
Montgomery.....	24	1	1	6	12	—	62	—	—	—	18	—	—	2	8	—	—	—	2
Prince George's.....	14	—	3	—	6	—	7	—	—	—	23	—	—	3	6	2	—	e-1	1
Calvert.....	2	—	—	3	—	—	—	—	—	—	—	—	—	1	1	—	1	—	—
Charles.....	1	—	—	3	3	—	1	—	—	—	—	—	—	—	2	—	—	c-1	—
Saint Mary's.....	—	—	—	8	2	—	1	—	—	—	6	—	—	—	1	1	1	—	1
Cecil.....	—	—	—	14	—	—	—	—	—	—	1	—	—	—	1	—	—	—	1
Kent.....	10	—	1	—	6	—	11	—	—	—	—	—	—	—	—	—	1	—	—
Queen Anne's.....	1	—	—	—	2	—	1	—	—	—	—	—	—	—	1	—	—	—	—
Caroline.....	—	—	—	—	3	—	—	—	—	—	1	—	—	1	2	—	—	—	—
Talbot.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	2	—	—
Dorchester.....	2	—	—	—	10	—	—	—	—	—	—	—	—	—	—	—	10	—	2
Wicomico.....	7	—	2	1	65	—	2	—	—	—	—	—	—	2	—	1	14	—	3
Worcester.....	—	—	—	4	61	—	3	—	—	—	—	—	—	—	3	—	4	—	1
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	2
Total Counties.....	179	2	12	121	447	5	259	1	0	0	131	0	0	33	79	4	49		44
Baltimore City.....	374	2	25	10	999	1	142	0	0	0	99	0	0	47	116	16	433		27
State																			
Jan. 29–Feb. 25, 1954...	553	4	37	131	1446	6	401	1	0	0	230	0	0	80	195	20	482		71
Same period 1953.....	491	5	134	51	55	19	126	0	0	0	319	2	1	21	166	13	557		181
5-year median.....	491	5	69	—	710	7	158	1		0	154	1	2	41	202	43	533		71
Cumulative totals																			
State																			
Year 1954 to date.....	1167	4	53	218	2137	10	772	2	0	0	349	2	0	169	311	38	1121		132
Same period 1953.....	1042	6	183	87	133	27	234	1	0	0	530	2	2	44	407	25	1244		267
5-year median.....	866	11	97	—	1250	14	282	3		0	283	3	6	93	383	81	1073		131

c = congenital syphilis under 1 year.
e = infectious encephalitis.



Blue Cross - Blue Shield



BLUE CROSS IN 1953—A PROGRESS REPORT

R. H. DABNEY*

In November 1937, twelve public-spirited men set in operation a "bridge to health" which, in the course of just one year, spanned the financial chasm between fifteen Baltimore hospitals and 32,000 citizens of the community. Since that time, the traffic of people going to hospitals has multiplied so rapidly that in total, Maryland Hospital Service (Blue Cross) has paid out \$54,300,000 to provide hospital services for the people of Maryland.

Today, sixteen years later, the bridge is stronger and better able to bear the weight of the heavier traffic. Against a background of increasing population within the State and steadily rising costs of hospital care, Maryland Blue Cross has grown from a modest blueprint to a major community institution embracing all of the forty voluntary general hospitals in the State and 869,000 of its citizens. In 1953 alone, the total payments to hospitals amounted to \$11,360,000 for the 124,000 Blue Cross members who needed hospital care.

The "bridge to health" is suspended on three main supports, namely; (1) membership growth, which means community acceptance, (2) utilization, or the rate at which members go to hospitals, and (3) the financial situation. Each support must withstand the stress and strain of changing conditions, and must always be strong enough to carry the basic Blue Cross objectives of service to the community at the lowest possible cost. This report for 1953 will give you a picture of the strength of Blue Cross in Maryland today.

Membership

In 1953, one out of every three persons in Maryland was a Blue Cross member. Although the net increase in membership was not as great as in pre-

vious years, this year's final total of 869,000 members represents an increase of approximately 9,000 throughout the State—and is a new record high. In Maryland, 43.9 per cent of the population (excluding areas suburban to Washington) are now enrolled, as compared to a national average of 28.4 per cent. Blue Cross membership in Maryland continued to rise in 1953, but the rate of growth slowed down due in part to the ever-increasing commercial competition in the field.

Blue Cross Enrollment

1938—First Year	32,454
1946—Postwar Year	441,284
1953—Current Year	868,775

Utilization

Blue Cross is proud of the service it renders to the community, and the extent of that service can best be judged by the number of members who went to the hospital, the length of time they stayed, and the payment made. In 1953, more subscribers were hospitalized than in any other year—124,375, as compared to 110,000 in the previous year. The average in-patient stay was 7.24 days (slightly down from 7.30 days in 1952), and the average payment per case rose to \$125.65, as compared to \$118.85 in 1952.

1952		1953
109,958	Subscribers Hospitalized	124,375
643,364	Days of Care (In-Patient)	671,390
\$118.85	Average Payment Per Case (In-Patient)	\$125.65
\$10,257,270	Total Hospital Payments	\$11,360,495

Financial Strength

A sound financial condition lies at the base of membership and utilization. In 1953, subscription income—boosted by a rate increase in the early part of the year—rose to an all-time high of \$13,217,050, a 26% increase over last year. But at the same time, hospital costs continued to rise and more and more patients entered hospitals.

After two years of deficit operations when reserves had to be tapped to make ends meet, Blue Cross

* Executive Director, Maryland Hospital Service, Inc., Maryland Medical Service, Inc.

crossed over onto the black side of the ledger in 1953.

1952	Disposition of income	1953
97.0%	Hospital Care	85.1%
7.3%	Operating Expenses	6.0%
-4.3%	Subscriber Reserves	8.9%
100.0%		100.0%

Significantly, operating expenses continued to go down, as they have been doing for the last eight

years. Subscriber reserves were increased, and as of December 31st they were sufficient to provide for 4.13 months of hospital care at the present average rate.

The continued success of Blue Cross attests to the fact that it fills a real community need—and serves as a “bridge to health” for thousands of Marylanders. Blue Cross will continue to prosper with the sympathetic and enthusiastic support of the public, the hospitals, and the medical profession.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service, Washington 25, D. C.

The Sixth Annual Symposium on Recent Advances in the Study of Venereal Diseases will be held in the auditorium of the Department of Health, Education, and Welfare, Washington, D. C., on April 29 and 30, 1954, it was announced today by Dr. James K. Shafer, Chief of the Public Health Service's Division of Venereal Disease.

The sessions are open to all physicians and workers in allied professions, who are interested in participating. These symposia usually draw hundreds from all parts of the country and are the occasion for exchange of the latest available information by some of the outstanding authorities in the field of venereal disease.

The topics that will be discussed at this symposium will cover many aspects of venereal disease control including basic and clinical research, serology, epidemiology, treatment, program operation, and professional education.

ON BEHALF OF BETTER DOCTOR DISTRIBUTION

AMA Special Report No. 16

Quoted from a Statement of the American Medical Association To the Committee on Interstate and Foreign Commerce House of Representatives by Walter B. Martin, M.D.

Because many problems of so-called doctor shortage are in reality problems related to physician mal-distribution, the American Medical Association has established a placement bureau to serve as a clearing house for information in answer to requests from physicians seeking a location and from communities seeking a physician. Placement programs are now in active operation in at least 37 states and at least 32 are sponsored by state medical societies. A. M. A. is sponsoring rural health conferences and programs and preparing literature to help communities attract physicians in an effort to stimulate public as well as medical efforts to bring doctors into needed areas.

Woman's Auxiliary to the Medical and Surgical Faculty

MRS. CHARLES H. WILLIAMS, *Auxiliary Editor*

FOREWARNED IS FOREARMED

MRS. R. WALTER GRAHAM, Jr.

All thinking people since the time of the Revolutionary War have agreed that our country should be responsible for its soldiers injured in battle. In recent years, however, this policy has been relaxed to the extent that now almost 85% of the patients cared for in V. A. hospitals are being treated for injuries or diseases that have no connection whatever with war. Moreover, a large proportion of these patients could pay for treatment in private hospitals. Instead, they have signed a pauper's oath declaring that they are indigent. Since no effort has been made to prove the validity of such statements, the abuse has become increasingly widespread.

As of August 31, 1953 there were more than 20,000,000 veterans in an overall population of 160,000,000 people. Approximately 80,000 more are being added each month. By 1970 over 86% of all living veterans will be forty-five years old or over and 2,000,000 will be sixty-five or over. This means more and longer illnesses increasing the length of stay, costs and personnel requirements in the hospitals. Already the average stay in V. A. hospitals is thirty days compared to seven and a half days for a patient with similar disabilities in a civilian hospital.

The Nation's physicians view this prospect with concern. They question the end results of such a tremendous program; is it a proper charge on the remainder of the population, will it bring the best medical care to the veteran and will it undermine the civilian hospital program of the Nation?

On July 31st 1952 the V. A. operated 154 hospitals, an increase of 25 in three years. These 154 hospitals operate 116,986 beds. In 1952 the V. A. was constructing 18 new hospitals and four additions with a total of 13,231 beds. In the planning stage are six new hospitals with 5,000 beds. The V. A. now maintains *three* times the number of beds needed for treatment of service-connected cases. Of

22,613 veterans awaiting admittance as of June 30th, 1953, only *three* had service-connected disabilities.

Many medical authorities are convinced that the V. A. cannot attract personnel to staff more than 120,000 hospital beds, although it is proceeding with a program providing more than 152,000 beds. This is creating an artificial shortage of doctors and other health personnel through its duplication of hospital facilities. There will not be an adequate number to staff both the expanding V. A. and civilian hospital programs. The Federal Government duplicates facilities by providing funds for hospital construction for two classes of citizens—for civilians through the Hill-Burton Act, and for veterans through V. A. The end result of this duplication is that government hospitals compete with civilian hospitals for personnel and for non-service-connected patients who should be treated in civilian hospitals. It is becoming increasingly difficult for civilian hospitals to operate at a reasonable cost because of this funneling off of both personnel and patients. This conflict is causing a continual increase in the cost of hospital and medical care for persons who must pay their own way.

The A. M. A. feels that the Hill-Burton Act improves the availability of hospital care for the entire population at less cost to the taxpayer. The A. M. A. believes also that Congress should decide:

1. Whether existing legislation providing care for veterans with non-service-connected disabilities is sound.
2. Whether the Federal Government should continue to engage in a gigantic medical care program in competition with state, local and private institutions.
3. Whether the ever-increasing cost of such a program is a proper burden to impose on the taxpayers of this country.

Since the A. M. A. has stated its position clearly and unequivocally, it is proper that the women of the Medical Auxiliaries should watch the trend and be prepared to back up their husbands. Should the need arise, be organized and ready to help.

TENTH ANNUAL CONFERENCE*

MRS. ALBERT E. GOLDSTEIN

The conference was held at the LaSalle Hotel, Chicago, Illinois, November 18, 19 & 20, 1953.

Registration opened at 9 a.m. and Mrs. Leo Schaffer, National President, called the meeting to order at 10 a.m.

After the invocation, pledge of loyalty, welcome and introduction, at which time our own Mrs. George Yeager, Constitutional Secretary, was introduced, Mrs. George Turner, President-elect, was presented and conducted the conference.

Following the roll call at which time the President and President-elect of Maryland responded, the chairman asked the president to give her report. Mrs. Schaffer talked on "The Health Education Project" and the work that lay ahead of us and used the slogan, "Together We Progress."

She mentioned 170,000 physicians living in the United States—90,000 of them bachelors—and just 60,000 Auxiliary members. She warned us to get busy. We were told to look for startling information from the National Foundation concerning Polio. The trial vaccine and gamma globulin inoculations are advancing research so rapidly that a third of the March of Dimes receipts will be contributed to Polio Prevention Program.

She talked on the Crusade for Freedom, with its three strong arms:

1. The American National Committee for a free Europe.
2. Radio Free Europe.
3. The American People (demonstrating that the way of free man is best).

Be an alert citizen.

Learn all you can about the menace of Soviet Imperialism and support the Crusade for Freedom.

The National Convention date was announced June 21 to 25, 1953, at Fairmount Hotel, San Francisco.

The speaker closed her talk with a line from Longfellow's Psalm of Life and symbolized it when

she said, "He who would leave footprints on the sands of time must wear work shoes."

Dr. Ernest Howard, Assistant Secretary of the A. M. A., addressed the conference on the Veterans' Medical Care Program.

The A. M. A. House of Delegates, June 1953, recommended:

1. Congress enact legislation limiting V. A. Medical care and hospitalization benefits to veterans with peace-time and war-time services whose disabilities or diseases are service-incurred or aggravated.

2. Service to veterans with war-time service suffering from Tuberculosis or Psychiatric disorders of non-service-connected origin who are unable to defray the expense of hospitalization.

A total of 104,279 patients were in V. A. hospitals in June 1953; 65% of these patients were receiving medical care of illnesses or accidents incurred in civilian life following military discharge.

In a survey of 500 patients picked at random being treated for non-service-connected ailments in V. A. hospitals, 366 had annual incomes of from \$4,000 to \$50,000.

PROGRAM AND PUBLIC RELATIONS

The first panel on Wednesday's Program correlated with Public Relations. Mr. Leo Brown, director of Public Relations of the A. M. A., talked on Public Relations seasoning. He spoke of two types of public relations:

Internal—Relations with one another.

External—Relations with general public.

Contacting other organizations as hospital auxiliaries and other groups such as P.T.A. was stressed. In some communities

1. Medical students' wives were organized.

2. Contact with the aged.

3. Collection of sample drugs and used instruments for medical and surgical relief committee.

All of these projects are basic tools for good public relations.

THE A. M. E. F.

The American Medical Education Foundation panel had Mr. Hiram Jones as the speaker. He felt the best public relations project of the Auxiliary was the A. M. E. F. He suggested that State Chairman of Auxiliaries should handle all checks, and money

* The report of the Tenth Annual Conference for State Presidents, Presidents-Elect and National Committee Chairman of the Woman's Auxiliary to the American Medical Association.

should be sent in at intervals. The seventy-five approved medical schools turn out 6000 doctors a year. Last year forty-two state Auxiliaries contributed \$22,632.

Some means of fund raising for A. M. E. F. were:

1. Subscriptions to magazines
2. Memorial cards
3. Fashion shows
4. Coffee & Donut Breakfast \$1.00.

The speaker advocated the Hill-Burton Act which encourages communities through mutual appropriations to meet their own hospital needs. Two million dollars are expected from the medical profession this year and eight million is hoped for from industries.

LEGISLATURE

Mrs. Quayle of Washington, D. C. was chairman of the panel.

Mr. Joseph Stetler talked on the Legislative Program of A. M. A. for 1954.

Some bills we were asked to support were:

1. The Bricker Amendment opposing international treaties.
 2. Tax legislation which would enable doctors to deduct for graduate study.
 3. The Pension Plan allowing each individual doctor to put aside \$7500 a year tax free.
 4. Veterans care for service-connected-disability.
- Ten important bills to watch and guard against were:

1. Universal Military training of doctors.
2. Extension of social security to include physicians.
3. Federal aid to private health insurance plan.
4. Free hospital benefits under old age and survivors act.
5. Doctors' draft.
6. Federal aid to medical education.
7. Permanent total disability insurance.

The speaker urged every one to know his congressmen and to become acquainted with them.

CIVIL DEFENSE

The conference was urged to awaken doctors to the necessity of civil defense. The President, Mr. Eisenhower, is conscious of preparation for any emergency. Doctors should be. If we have a disaster patients will run to a hospital and hospitals may be

blown up too. Individuals should know what to do and where to go first.

NURSE RECRUITMENT

Mrs. M. L. Henry of Oklahoma talked on loans versus scholarships. One out of every four nurses in their state failed to complete her nursing course on scholarship and two out of twenty failed on loans. Oklahoma has shifted from scholarships to loans. Those accepting loans are more interested in their future and expect to pay when they graduate. No time restriction is placed on them. The loans are created in the same manner as scholarships and are perpetual.

MENTAL HEALTH

Dr. Richard Plunkett said mental illness is primarily an educational problem.

1. The important step is to educate the public.
2. Interest Public Schools in the problem and make it part of their program.
3. Help create better institutions.
4. Good public relations with Health Organizations.

TODAY'S HEALTH

Mrs. Richard Stovie, Chairman.

Mr. Robert Enlow, Director of Circulating Department.

Selling suggestions were:

1. Contact other groups to talk up subscriptions through your Auxiliary.
2. Work through doctors' offices.
3. Give gift subscriptions.
4. Give subscriptions to new mothers.
5. Beauty shops subscriptions.
6. Christmas gifts.

Have a speaker talk on, "America's No. 1 Killer is Overweight." Read "Today's Health."

RURAL HEALTH

This panel concerned other communities more than Maryland. In some sparsely populated areas public relations were very necessary in aiding the doctors to build clinics and to plan P.G. courses for young doctors. One doctor's wife reported that she took a young doctor into her home and did his laundry. The panel urged the community to use the new doctor rather than go to a distant city.

ORGANIZATION

Mrs. Flanders, Chairman.

Organization was discussed on county level.

1. Have committee on membership remember widows and retired doctors' wives.
2. Encourage medical societies to place a check before names of doctors whose wives are Auxiliary members when they print the roster.

BULLETIN

Mrs. Simonds, Chairman of Bulletin, gave us an acrostic on the Bulletin.

B—be a good subscriber.

U—utilize all contents.

L—look at all pages.

L—leading facts.

E—every member a subscriber.

T—timely tools.

I—inside information.

N—needs your support.

The bulletin is the president's best friend. Many problems are answered here. The county chairman cannot do a good job if she does not subscribe.

On Friday we had a very interesting tour through the A. M. A. Building. For those who have never been there, it is a must to go through this eight story building at 535 N. Dearborn Street, Chicago, Illinois. Starting from the top floor where the Auxiliary offices and auditorium are located, we toured down to the sub-cellar of this great institution.

We visited the following Councils:

Medical Education and Hospitals

Pharmacy and Medicine

Research

Food and Nutrition

Physical Medicine and Rehabilitation

Industrial Health

Medical Motion Pictures

Cosmetics

Laboratories

Exhibits

Investigation

Publications

Legislation

Rural Health

Public Relations

We also visited the A. M. A. Library, one of the most outstanding in the world.

All of these departments had well equipped offices, manned with trained personnel. Every doctor in the United States should visit this institution. He would feel that the dues he pays to the A. M. A. are a great investment.

Following the tour, we saw two films, sponsored by the A. M. A.:

"Operation Herbert"

"A Citizen Participates"

Then we viewed our own Maryland film, "The Girl with the Lamp." When I saw the film and heard the enthusiasm that followed, it was a vision realized and a feeling of a job well done. No one but Mrs. George Yeager, Mrs. Edward Stewart and their committee will ever know the Blood, Sweat and Tears that went into the work of this production.

From the experience gained with this project, I suggest if one has an idea that he thinks is good for the betterment of the work he is deeply interested in, do not let it die. Take it to someone who can help develop it. People are ready to grasp new ideas if they are worthwhile.—Only hard work will bring results.

LUNCHEON MEETING

WOMAN'S AUXILIARY TO THE
MEDICAL AND CHIRURGICAL
FACULTY*

Introduction of Guest Speaker by Dr. Maurice C. Pincoffs

DR. PINCOFFS: Due to the kindness of your President, I have the honor of introducing the speaker of the occasion. This man on my right has had a very remarkable career. There is a theme that runs through it; one of broad interests, and one of success. He has been many things.

Shortly after graduation, he entered on a long career in the army as a regular Army Medical Officer. He showed his gift in the way of foresight in that he very promptly took up an interest in the embryonic Air Force and rose to be commandant of the first school of Aviation Medicine. He never gave up that interest.

After he left the army, he became the first Medical

* Annual Meeting, April 29, 1953, Sheraton-Belvedere Hotel, Baltimore.

Director of Civilian Aviation, and to this day he is the Chief Editor of the Journal of Aviation Medicine.

He entered into practice and at once showed an interest not only in clinical medicine but in public health, and became a member of the Council of Public Health in the State of New York. He started his County Medical Society membership in Nassau County, New York, and soon was President.

Later, he became a delegate to the American Medical Association. It was not long before he was a Trustee of the American Medical Association. Soon after that he became Chairman of the Board of Trustees of the A. M. A., and then as you know, President-elect and now President.

In all this activity he has found time to become a diplomate of the American Board of Cardiology. He has delivered many papers on Cardiology, and has also developed an active practice in that field.

Dr. Bauer probably advises his patients often to cut out some of these numerous activities and to get plenty of rest. The kind of man you are going to hear is a man who was in Des Moines yesterday, and will be in New Orleans tonight. In other words he is a typical physician, he does not follow his own advice.

I am sure that the husbands here will agree with me that if I stopped at this point, I'd be greeted with questions concerning whether our guest is a married man and if a married man his wife's maiden name and how many children. I have hunted about a bit to get more exact details knowing I was to introduce Dr. Bauer, but these vital statistics were not readily available.

Through his kindness, I can now tell you something I am sure you did not know. This man of foresight and vision is married, and his wife is a Marylander, she was Miss Margaret Buckler of St. Mary's County. He has two children, a daughter and a son and four grandchildren.

I think we all would like to pay tribute to our guest. I am sure all of you feel as I do that he is a man who has shown throughout his career—and I have only mentioned a part of it—an extraordinary breadth of interest and an extraordinary ability to go to the top, whatever he undertakes. Also, I am sure that all the husbands will agree with me that one example is that he found his wife in Maryland. Dr. Bauer.

(Audience rises in tribute)

*Address by Louis H. Bauer, M.D.**

DR. BAUER: Thank you, Dr. Pincoffs. Madam President, Distinguished Guests, Ladies and Gentlemen:

I am very glad to have the opportunity of being here in Maryland. I have been here many times before, but never in an official capacity.

I don't know whether Dr. Pincoffs' remarks show anything other than that a man can easily be sucked into a lot of things without realizing it. I once made a remark years ago that if a man wanted to protect himself in organized medicine, if given a job he shouldn't do it at all or do a lousy job so nobody would ever ask him to do anything again. If you do a job anybody admires half way, then you're licked.

I would like however, to urge the members of the medical profession to take more interest in medical affairs other than a strictly scientific one, because that is one of our difficulties at the present time. Too few doctors think outside of the scientific realm of medicine, and if we are to continue in the United States the system of medicine which we have, then doctors have got to take an interest in the social and economic side of medicine as well as in the purely scientific aspect.

Our County Societies in most areas of the country—I don't know how it is here in Baltimore—but I know, by going around the country, these County Societies are poorly attended. The result is that the County Society has lost a great deal of influence it formerly had in health affairs in the community, because of a lack of interest.

The public is taking an increasing interest in medicine but it needs leadership and there is no one who can give that leadership to the community like the doctor. If he does not do it then somebody else will and the leadership will not always be of the best interest to either the public or to medicine itself.

We hear a great deal about the American Medical Association and not all of it is complimentary. I think perhaps some of the difficulty has been that during the last four years we have had a fight on our hands and that particular fight has been headlined in the newspapers to the exclusion of everything else the Association does. People have begun

* President—American Medical Association, 1953.

to think of the Association as being a political organization where, as a matter of fact 90% of the activities have been in the scientific field and always will be.

The American Medical Association, I think, has been taken for granted by too many doctors. They have not realized what the Association has done for them. I frequently hear "why should I belong to the A.M.A., what did it ever do for me?"

May I say the entire environment of medical practice today, and the system under which you practice, is due to the American Medical Association. There is no medical organization in the world which has done so much for the general public or for the practitioner as has the American Medical Association.

I recently returned from a trip around the world and I was quite startled to find that many doctors in other hemispheres know more about the American Medical Association than a lot of doctors here in the United States. They wish their organization could be patterned after the American Medical Association and be as influential as that organization is.

Now why do I say the American Medical Association has done more for the public than any other organization? Let us look back a little bit. Half a century ago, medical education was at a low ebb in the United States. At that time the American Medical Association decided to engage in a campaign to raise the standard of medical education in this country. A lot of rocks were thrown at the Association particularly by those concerned with the so-called proprietary school of medicine. Nevertheless the campaign went on, and as a result it represents one of the finest things the American Medical Association did for medical education because today it is not excelled anywhere in the world.

This country has become the center for medical training, whereas half a century ago our doctors used to go elsewhere for their training. Now, foreign doctors come here for their training.

About the same time there were no standards whereby the public or profession could judge the value of a drug or therapeutic agent. Gradually various councils like the Council of Pharmacy and Chemistry, the Council of Food and Nutrition and the Council of Physical Medicine and Rehabilitation were developed to make appropriate studies.

To-day the result is that if a drug or apparatus has the seal of approval of the American Medical Association it is reliable. You thereby know it is a drug based on sound pharmacological and clinical experience, and that it is not a secret remedy; that the formula is open to anybody who wants to read it; that it has been tested; that as far as anyone can tell it is without danger or if there is a danger the danger is plainly marked on the preparation; and that there is no unwarranted claim made as to its efficacy.

Standards in industrial health have been raised. The Council on Rural Health has done a tremendous job through cooperation with the National Grange and the National Farm Bureau, in raising the standard in rural areas and making medical care available in rural areas. There is no aspect of medicine which has not been affected by the American Medical Association, yet people do not stop to realize but take all this for granted.

Now, with any large organization—and there are 140,000 members of the American Medical Association—there are bound to be differences of opinion. That is healthy. There'd be no use having an association if everybody thought exactly alike. We must remember however that the majority has to rule until the minority can persuade the majority that they are wrong.

We hear a great many claims about the American Medical Association being a hierarchy and undemocratic. Well, I think that the American Medical Association is probably the most democratic, large organization that I know. How are its policies determined? You doctors belong to County Societies where you have a vote; you elect delegates to your state organization and those delegates in turn elect delegates to the American Medical Association. Thus they form the policy-making body of the American Medical Association. Delegates from the states are in proportion to the number of member doctors of the Association. All legislation and all policies are adopted by the House of Delegates of the American Medical Association, more or less similar to Congress. When resolutions are introduced, they are referred to the Reference Committee. The Reference Committee holds open hearings to which any member of the Association regardless of whether he is a member of the House of Delegates, may appear and testify for or against

that particular report or resolution. You don't have to belong to the policy-making body to make your wishes and desires felt. A lot of doctors don't know that.

When the Committee has heard all the testimony it reports back to the House of Delegates. You have more privilege than you have with Congress. Congress limits the time to hear people. There is no such limitation in the American Medical Association.

Now, as to hierarchy. I was elected in 1944 to the Board of Trustees. When I was named President-Elect in 1951, there was not a single person on the Board who was there in 1944. You don't have a hierarchy with such a turnover.

We hear a great deal about needing more doctors. I think we need slightly more doctors and we are getting them. What we need most is a better distribution of doctors. We have in the United States about one physician to every 750 persons, which is more than any other country in ratio of population by 25%. Our nearest competitor is Great Britain with one doctor to every 1,000 persons. Our doctors are not well distributed. In New York City there are one to every 450 persons, and in the South there is one to 1,800.

How are you going to get doctors from the city to go into rural areas? Not by doubling or tripling them, they will congregate in a city. There is only one way and that is by affording them facilities to practice good medicine. No doctor who spends ten to thirteen years of his life in training to be a physician and practice modern medicine is going to settle in a community where he has to practice an archaic type of medicine, and you can't blame him for not doing it.

The question has to be solved by setting up facilities, attracting and selling by amortization over a period of years. Where that is done there is no trouble getting doctors into rural areas. We must urge communities to see that these facilities are available in order to obtain doctors.

We need more widespread public health facilities than we have. Where Public Health stops and where it begins has been argued. At least we can agree environmental sanitation, production of good milk, water supply, prevention of communicable disease are areas for public health officials because they

have to be carried out on the community basis and some require police power.

Then we need a program for caring for chronic invalids. That means not only chronic disease like Cancer and Tuberculosis but also degenerative diseases which accompany old age. We have commissions on chronic illness, trying to solve this problem, I hope within the next year they will come up with an answer. We have an aging population. The reason we have a great number of people with chronic degenerative disease is because they have had good medical care; the span of life has increased 21 years in the last half century. The result is that millions of people are now living to middle and old age who would have died in infancy and childhood. Heretofore they would have died before they reached old age, and unless we find some method of preventing or controlling these degenerative diseases, the problem will be an increasing one. It is an increasing one, too, because of what I consider the stupid, economic ideas which we have in this country, that everybody who is sixty-five years old should be put on the shelf. I don't know of any way to kill anybody when he has been active than to make him retire and do nothing. But we are working on those things and I hope the solution is going to be found.

Another gap in our program is Care for the Indigent. Some States have very satisfactory programs for the care of the indigent, others do not. But that is no reason why they should not have it in every area. To have it so there is good cooperation between the Welfare Department—or whatever department it is in the State that handles the care of the indigent and the aged, and the medical profession.

Further, we must expand our Voluntary Health Program. It is growing by the millions each year. We now have nearly eighty million people covered for hospital expenses. We have another sixty-six million protected against surgery and maternity, and another thirty million insured against medical care in whole or in part.

There are two groups requiring protection in the Voluntary Insurance Program. One is protection of people over 65;—that is rapidly being taken care of. We need voluntary plans to start with. If Voluntary Insurance Plans never had anyone but people over sixty-five, they'd have gone bankrupt quickly. But now they have a sound footing and are able to cover

that group. More and more plans are increasing the age limit and many of them now have no age limit. Once you're in, you're in as long as you live so long as you pay the premium.

The other is insurance against long duration illness—the person sick for a year or two years. Only a small proportion of the population are subject to such illness but nevertheless some method must be found to give them protection in case they do suffer from such a long, drawn out illness. And those two things have got to be worked out, and can be worked out on a voluntary basis in my opinion, without having to go to the government to get them to finance it and which I think would be disastrous.

One other thing I think the profession can do and that is the development of leadership in the community. Community Health Councils are being formed in various areas because medicine is no longer an individual matter between doctor and patient. It involves the Dentist, the Nurse, and in the case of low-income groups, Social Welfare, Public Health officials, etc. They must work together as a team. The voluntary health agents come in too. Particularly in certain groups they must make a team to solve these problems together. And there is no one who is better qualified than the doctor and I urge that he take an interest in the community and develop civic responsibility as well as scientific responsibility.

I think all of these problems can be worked out through our American way of life without having to adopt the schemes in vogue in other countries; in fact in most other countries. I have visited Europe twelve times in the last six years and went around the world once last fall. I have had an opportunity to see a lot of their schemes first hand. Now I don't want to criticize any country for what that country does; that is their own business. But I can say this, whether or not these plans work well in that country, I have yet to see one I want to see adopted in this country. Every one that involves participation by the government is bankrupt. All are operating in the red. The way the government endeavors to reduce debts is to restrict benefits to the patient, restricting medicine and treatment by the doctors, and, of course, remuneration to the physician so it becomes an assembly-line type of medicine.

Socialized Medicine I think is no longer an immediate danger in the United States, but we must

remove these gaps in the program which I have mentioned, and if we do that I think we can permanently keep that danger away.

One other item on the domestic level is Medical Education. Our medical schools have been in a tough spot financially. That is due to the high tax laws we have now, which have been drying up private philanthropy, and there aren't any large fortunes left. Consequently the schools are having difficulty in getting money to continue operation at a high level.

There are two schools of thought on the problem. One, is that funds can be raised through private enterprise, and the other it can be raised by government contribution. Some people say, why not have the government participate in medical education, the government is the only one who has money and it probably wouldn't control medical education anyway. I disagree on both counts. In the first place the government hasn't any money which it doesn't take out of your pocket and mine. In the second place I'm not sure the government wouldn't endeavor to control medical education if it got its foot in the door. In my inaugural speech last June, I cited an instance where the divisional education had reprimanded a teacher in the mid-west because he expressed a personal opinion. He was told the publicity given to his comments might result in the entire area being excluded. If they do that because somebody cites a personal opinion we cannot be too sure they won't open their area to controlling medical education. I don't think that is a danger at the moment but you have to look with a long range viewpoint.

Suppose the government did subsidize our medical schools for a brief period. We now obtain certain funds from private sources; those funds would dry up; the people would say the government is doing it then why should we contribute, and then if the government withdrew or refused to support it, the schools would be worse off than now.

Every physician has a responsibility to his medical school. No doctor paid for his medical education. He paid tuition but that is all, and maybe that represented no more than one-third of the cost to the school educating the doctor. The rest came out of endowment.

Now, endowments are shrinking, and incomes from investments are shrinking and schools no longer have

sufficient funds to meet that deficit and we have to get it from somewhere if we do not want it from government. We must get it from industry and doctors. I hope every doctor will feel that he does have an obligation to his school whether he contributes directly to the school or to the medical foundation. He should give something to the school to repay the debt which he owes the school. If he contributes to the American Medical Education Foundation the Foundation will either distribute it among all of the schools or if an individual school is specified it will go to that school. Every dollar you contribute goes to the school. Not one cent is deducted for administrative purpose.

One other item I would like to mention, we don't have much danger of socialization from domestic level but we do have a little danger from the international level.

There are more and more problems which are being discussed and decided on the international level which pertain to health and medicine. One of the international organizations which is having a good deal to say about medicine, particularly in the field of Social Security is the International Labor Organization, which has been in existence for twenty years in the United States. I don't know whether you know much about ILO or not. Each year they hold a convention; two men represent the government, one represents management, and one man represents labor. Last year they discussed the medical aspects of Social Security; they brought in a report which recommended compulsory health insurance or government controlled voluntary insurance for every nation adhering to ILO. All they need to put that into effect is for the United States to adopt it as a treaty and you'd have it, and the House of Representatives wouldn't have a thing to say about it.

Now the World Medical Association found out about this and drafted a report representing what the doctors think of the Medical aspects of Social Security and went to the ILO and asked that they distribute our report as well as the one they compiled and they refused to do it. We got it distributed but not through any help of theirs. That report went into the *Journal of the American Medical Association* of May 31st last year. Many of you may have seen it.

The World Medical Association is an organization

of National Medical Associations, and may I differentiate from the World Health Organization. The World Health Organization is a branch of the United Nations and represents governments in the field of Health—more particularly in the field of Public Health. The World Medical Association, however, represents the doctors and there are now forty-three nations within its fold comprising within the National associations of those forty-three nations about seven hundred thousand doctors. I think the voice of those doctors should be heard when it comes to matters pertaining to health and medicine. Without the World organization there was no one to speak for the practicing physician. Everything is being discussed and decided from the government viewpoint.

Government has a place in Medicine which I mentioned already but Government should keep in its place rather than interfere in medical care per se, or doctor-patient relationship. But without anyone to speak for you, these things will be decided without your voice, whatever.

We have set up in this country a committee known as the U. S. Committee of the WMA, in which memberships are passed and we have agreed to underwrite expenses of the association and the members have all our publications including the bulletin.

Now these doctors throughout the world, I have found, think surprisingly alike and it is also interesting to know they seem to have the same problems no matter where they come from. Those problems may differ in degree but they are the same basic problems and the doctors may differ as to details how the problem should be answered, but basically they think the same.

In other words, medicine has proved to be a universal language and when you start with that as a basis you find that suspicion and distrust quickly disappear, and these doctors when they congregate together find that the fellow from the other country doesn't have horns or a fork-tail after all.

So I feel doctors can do more in improving relations than the diplomat agent. We have shown that through the WMA. One of the differences is language. We deal in English, French and Spanish. Those who know more than one language know how difficult it is to translate words and have them mean the same thing in another language. You must translate the idea back of the word. In 1948 when the World

Organization was meeting they spent a day and a half arguing about twelve principles, but ninety-five per cent of the arguments were through difficulties because of language. The minute all language barriers were removed those twelve principles were adopted unanimously and there were thirty-one nations present at the time they were adopted. So I do think it speaks well when doctors speak alike.

There is a story, in the First World War about a Japanese cruiser chasing a German Gunboat into Guam Harbor. One of the German officers fell in love with an American nurse but had a difficult time because he could not speak English. He wrote a letter and by dictionary translated it into English. One of those letters made a hit because she married him. "The fragrance of your presence intoxicated me." When translated: "The smell of your body makes me drunk." I think this illustrates you cannot translate the words. He had the idea but didn't quite get the words.

I probably have talked long enough and you have meetings this afternoon. I want to pay tribute to the Auxiliary. There are a lot of things doctors could do but won't and the wives do it for them. We could have been behind the eight ball a number of times had it not been that the Auxiliary pitched in and helped out. I understand you are a young Auxiliary

but I am sure you will be able to do a great many things for the medical profession. To give an illustration, one State whose name I won't mention, had a woman legislator. A bill was going to be introduced which was greatly opposed by the whole medical profession—it had to do with quackery—and it was said the bill was to be introduced by this woman legislator. Of course if we had asked the doctors to do anything there would have been a half dozen who would have sent a telegram. But within a week in that State, the women of the Auxiliary bombarded her with over a thousand letters until she threw up her hands and asked them to get the women off her neck, that if she had ever intended introducing the bill she certainly wouldn't now.

So you see how effective the Ladies' Auxiliary can be. Now in closing, I want to thank you for your hospitality. I appreciate the opportunity of having been here and I wish you a most successful meeting.

(Applause) (Audience rises in ovation)

MRS. WILLIAMS, AUXILIARY PRESIDENT: Thank you very much, Dr. Bauer. Our warmest thanks for your message and for your presence in Maryland.

(Applause)

A. M. A. INDORSES BILL FOR EXPANDED HILL-BURTON PROGRAM

A. M. A. Washington Letter—No. 57

The American Medical Association has given its formal indorsement to the first of the administration's health bills, a 3-year, \$60,000,000-a-year program for Hill-Burton grants to build non-profit facilities for the chronically ill, nursing homes, diagnostic or treatment centers and rehabilitation units. The Association's position was outlined in a letter from Dr. George F. Lull, A. M. A. secretary and general manager, to Chairman Charles Wolverton of the House Interstate and Foreign Commerce Committee. The committee opened hearings on the bill (H. R. 7341) Feb. 4, immediately after winding up an extensive fact-finding study of health problems. The first witness was Mrs. Oveta Culp Hobby, Secretary of Health, Education, and Welfare, who urged favorable committee action.

The A. M. A. recommended that: (1) facilities for the chronically ill and impaired should be part of or near a conventional hospital, (2) the original purpose of the Hospital Survey and Construction Act (Hill-Burton) should be reaffirmed to make clear that any facilities built under the new program are for the benefit of the entire community.

ARTICLES OF INTEREST

DR. WALTER L. KILBY

Dr. Walter L. Kilby has recently resigned as Director of the X-ray Department of the University Hospital and Professor of Roentgenology of the University of Maryland Medical School in order to devote his entire time to the private practice of Roentgenology.

Dr. Kilby came to Baltimore in 1936 to become associated with Dr. Henry J. Walton. At that time he was appointed instructor in Roentgenology and Assistant Roentgenologist at the University of Maryland Medical School and Hospital. He was later promoted to Assistant Professor in Roentgenology, a position held until 1941 when he was appointed acting Professor of Roentgenology and Director of the X-ray Department following the resignation of Dr. Henry J. Walton who had held the position for about 30 years.

In 1940 Dr. Kilby was commissioned as Lieutenant in the United States Naval Reserve. Subsequently he was transferred to the Army where he received a commission as Major and was assigned to the University of Maryland sponsored 142nd General Hospital. He went overseas with this unit and served 27 months in the Fiji Islands as Chief of X-ray Service and later followed the unit to Calcutta, India where he served for 6 months. He was returned to the United States in April 1945, having been promoted to Lieutenant Colonel, and assigned to the Woodrow Wilson General Hospital, Staunton, Virginia as Chief of the X-ray Service.

Dr. Kilby was discharged from the Army in September 1945 at which time he returned to the University of Maryland and was appointed Professor of Roentgenology and Director of the X-ray Department of the University of Maryland Medical School and Hospital, a position he held until his recent resignation.

Dr. Kilby was born in Rappahannock County, Virginia where he received his early education. After graduating at the University of Virginia with a B.S. degree he devoted three years in the educational field. He entered the University of Virginia Medical School in 1929 and received his M.D. degree in 1933.

After spending a year at the Cincinnati General Hospital, Dr. Kilby returned to the University of Virginia Hospital where he remained two years as Assistant Resident and Resident Roentgenologist.

During his stay at the University of Virginia, he became a member of Phi Delta Kappa, Phi Chi Medical Fraternity, Alpha Omega Alpha and Iota Sigma, the latter two being honorary medical fraternities. Dr. Kilby was elected to the Raven Society, an honorary scholastic society, in 1932 and the same year he was elected president of the Medical School.

Dr. Kilby is a member of the American Roentgen Ray Society, The Radiological Society of North America, The American College of Radiology, The American Medical Association and the Baltimore City Medical Society. He has served as secretary and treasurer and chairman of the Radiological Section of the Baltimore City Medical Society.

FRANK KUEHL JOINS WASHINGTON STAFF

The AMA Washington Letter, No. 56

Frank Kuehl, an attorney with the Reconstruction Finance Corporation since 1933, will join the Washington Office of AMA as legal adviser. Before coming to Washington, Mr. Kuehl was assistant attorney general in Wisconsin for six years.

Book Reviews*

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them.

The Nursing Mother. Frank Howard Richardson, M.D., F.A.C.P., F.A.A.P., Licentiate American Board of Pediatrics. Pediatric Introduction by Clifford G. Grulee, M.D., Founder of the American Academy of Pediatrics, Chicago, Illinois. Obstetric Introduction by Nicholson J. Eastman, M.D., Obstetrician-in-Chief, Johns Hopkins Hospital, Baltimore, Maryland. Copyright 1953. Prentice-Hall, Inc., Publishers. 204 pages. Illustrated. \$2.95.

Breast feeding of the newborn has always been the rule among the poorer peoples of the world. Recently many modern mothers have found it necessary or have chosen to seek employment or a career; others have found the need for increased social life with less emphasis on household duties. Such desires or necessities have reduced the incidence of breast feeding in the more financially stable group of peoples. Many mothers are of the opinion that breast feeding can be successful by only a select few. All of these reasons have reduced the total number of breast feedings in the United States. This has been the reason for the writing of this book.

Dr. Richardson believes that most mothers can breast feed their infants if properly instructed; that breast fed babies thrive better than bottle fed infants. He produces evidence to show the superiority of breast feeding; he spends many chapters describing the proper method of preparation for breast feeding, the proper management of the infant during feeding, and the infant's behavior at this time; and finally he reemphasizes his material by using a question and answer method of instruction.

This volume is very well written, it maintains interest and is well printed. It should be a valuable aid to the pregnant and puerperal woman, and also a valuable guide for the obstetrician and pediatrician.

D. F. K.

Brain Surgeon. The Autobiography of Dr. William Sharpe. Director of Neurosurgery, Manhattan General Hospital, New York City. Foreword by John Haynes Holmes. Copyright 1952 by William Sharpe. The Viking Press, New York, and The Macmillan Company of Canada Limited, Publishers. 271 pages. \$3.75.

This is an autobiographical account of the career of Dr. William Sharpe, one of America's pioneer neurosurgeons. The son of a Scotch Presbyterian clergyman,

he states that his boyhood was spent in the slum areas of Pittsburgh, Chicago, and later Philadelphia. His success as a student at Harvard and during his four years in medical school and three years of hospital internship is attested to by the fact that during these ten years he earned approximately fifty thousand dollars by tutoring what he called "slothful students." In a fascinating manner the author relates his adventures as a graduate student in various European Universities, as a neurosurgical trainee under Dr. Harvey Cushing, and then as the first professor of surgery at the then newly established Harvard Medical School of China.

There then follow interesting and uninhibited accounts of the neurosurgical triumphs and failures of Dr. Sharpe and his contemporaries. The author, by virtue of his prominence in the medical profession and his vast and varied travels, is able to present to the reader interesting and informal aspects of the lives of people politically eminent as well as those renowned in the field of medicine.

Dr. Sharpe states that his reason for writing this book "in the first place" is to set forth his ideas on "the prevention of cerebral palsy by improved prenatal and obstetrical care so that the danger of intracranial hemorrhage at birth is minimized." Throughout the book the author repeatedly refers to the importance of intracranial hemorrhage in the newborn as a cause of cerebral palsy and the necessity of repeated spinal punctures until the bloody spinal fluid becomes clear. He very appropriately cautions that all cases classified as cerebral palsy are not born of such an etiology.

On November 9, 1915 Dr. Sharpe read a paper before the New York Academy of Medicine on this subject, and on the following day, much to the dismay of the author, the newspapers had "in a garbled and dramatic style" outlined his presentation on the first page. "Within a week my neurosurgical clinics at the Polyclinic were increased by the arrival of spastic children of all kinds. Unfortunately the vast majority of these cases were so badly impaired that little could be offered to improve their condition other than by massage and exercises." It is to be hoped that the lay and uninitiated reader will read carefully and understand the words of the author lest once again false hopes invade these many pathetic households.

W. H. M., Jr.

*The reviews here published have been prepared by competent authorities and do not represent the opinions of any official bodies unless specifically stated.

COMING MEETINGS

You Are Cordially Invited to Attend

The

THIRD ANNUAL PEDIATRIC SEMINAR

Sponsored by the Pediatric Department, University of Maryland, School of Medicine

Sunday, March 28, 1954

GORDON WILSON HALL, UNIVERSITY HOSPITAL, BALTIMORE, MARYLAND

- 10:00-10:05 Welcome. Dr. J. Edmund Bradley
- 10:05-11:00 The Management of Common Pediatric Cardiac Diseases. Dr. Rachel Ash, Associate Professor of Pediatric Cardiology, University of Pennsylvania, School of Medicine.
- 11:00-11:30 Discussion.
- 11:30-12:30 Practical Aspects of Liver Diseases in Pediatrics. Dr. Sydney S. Gellis, Assistant Professor of Pediatrics, Harvard Medical School, Senior Physician, Children's Medical Center, Boston
- 12:30-1:00 Discussion.
- 1:00-2:00 Lunch will be served in the auditorium on the fifth floor.
Moderator, Dr. C. Loring Joslin, Professor of Pediatrics, University Hospital
- 2:00-3:00 Early Diagnosis and Treatment of Tuberculosis in Children. Dr. Edwin L. Kendig, Jr., Assistant Professor of Pediatrics, Medical College of Virginia
- 3:00-3:30 Discussion.
- 3:30-4:30 Some Dermatologic Problems Seen in Pediatric Practice. Dr. Marion B. Sulzberger, Professor and Chairman, Department of Dermatology and Syphilology, New York University, Postgraduate Medical School, Director, New York Skin & Cancer Unit.
- 4:30-5:00 Discussion.
- Committee on Arrangements:* Edward G. Field, M.D., Samuel Shipley Glick, M.D., and Ruth W. Baldwin, M.D., *Chairman.*

POSTGRADUATE COURSES

Presented by the Baltimore City Medical Society, its Sections, and the Maryland Academy of General Practice.

DISTURBANCE OF WATER AND ELECTROLYTE METABOLISM

NEW CLASS ROOM—THE JOHNS HOPKINS HOSPITAL

Thursday Evenings, 8:00 p.m.

- April 1, 1954 Some Physiological Background to Problems in Water and Electrolyte Metabolism J. L. Lilienthal, Jr., M.D.
- April 8, 1954 Mechanisms and Treatment of Water and Electrolyte Disturbances in Medicine Kenneth L. Zierler, M.D.
- April 15, 1954 Water and Electrolyte Disturbances in Pediatrics and in Diseases of the Nervous System. Harold E. Harrison, M.D.
- April 22, 1954 Water and Electrolyte Disturbances in Surgery Eric Nanson, M.D.

NEUROPSYCHIATRIC SECTION

LEONARD J. GALLANT, M.D., *Secretary**Thursday, April 8, 1954, 8:30 p.m.**Faculty Building, 1211 Cathedral Street*

Some Considerations of the Interrelationships between the Hypothalamus, Anterior Pituitary, and Adrenal Cortex in the Response to Stress. Frank Engel, M.D., Associate Professor of Medicine, Duke University, Durham, North Carolina.

Discussants: Enoch Calloway, M.D., Instructor in Psychiatry, University of Maryland School of Medicine.

Jacob Finesinger, M.D., Professor of Psychiatry, University of Maryland School of Medicine.

RADIOLOGICAL SECTION

David N. Gould, M.D., *Chairman*H. Leonard Warres, M.D., *Secretary**Tuesday, April 20, 1954, 8:00 P.M.*

Brief important business meeting and election of officers for the coming year.

DOCTORS HOSPITAL

INSTITUTE OF POSTGRADUATE MEDICAL STUDIES

Tentative Program

INDUSTRIAL AND TRAUMATIC MEDICINE AND SURGERY

OPENING SYMPOSIUM—Tuesday Evening, April 13th—9:15 P.M.

“Occupational Disability and The Doctor’s Testimony”

LECTURES—

1. Wednesday, April 14
 - a) 3:00 P.M. Treatment of Eye Injuries
 - b) 3:30 P.M. The Ear in Industry
 - c) 4:00 P.M. Occupational Affections and Injuries of the Nose.
2. Wednesday, April 21
 - a) 3:00 P.M. Treatment of Burns
 - b) 3:30 P.M. Dermatoses
 - c) 4:00 P.M. Hand Injuries
3. Wednesday, April 28
 - a) 3:00 P.M. Pulmonary Diseases Due to Environment

PANEL DISCUSSION—Tuesday Evening, May 4th—9:15 P.M.

“Syndromes Arising from Skeletal Trauma”

Moderator—

“Head Injuries”—

“Cervical and Low-back Syndromes”—

“Fractures and Dislocations”—

LECTURES—(Continued)

4. Wednesday, May 5

- a) 3:00 P.M. Fatigue, Stress, and Malingering in Industry
- b) 3:45 P.M. Menstrual Disturbances and Pregnancy in Industry

5. Wednesday, May 12

- a) 3:00 P.M. The Heart and Blood Pressure in Occupational Disability
- b) 3:45 P.M. Peripheral Vascular Diseases due to Occupation

6. Wednesday, May 19

- a) 3:00 P.M. Radiation Hazards
- b) 3:30 P.M. Acute and Chronic Poisonings

CONCLUDING SYMPOSIUM—Tuesday Evening, May 25th—9:15 P.M.

“Medico-Legal Aspects of Sudden Death from Disease or Injury”

Course under direction of Wm. Schuman, A.B., M.D.

Open to all physicians

Registration required

Address all inquiries and registrations to:

Postgraduate Institute

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2724 N. Charles St.

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A.M.A. NEWS RELEASE—WASHINGTON OFFICE

THE MONTH IN WASHINGTON

Washington, D. C.—Some parts of the Eisenhower administration's broad health program are making good progress on Capitol Hill, while others are virtually standing still or bogged down in the technical complications that are always a threat to new legislation. Well ahead of the other proposals, and possibly destined for enactment, are bills to broaden the scope of the Hill-Burton hospital construction law and to liberalize income tax deductions for medical expenses.

The House Interstate and Foreign Commerce Committee, under chairmanship of Rep. Charles Wolverton (R., N. J.), wound up its long fact-finding study of voluntary health insurance plans and immediately started hearings on the Hill-Burton changes. The purpose is to amend the Hill-Burton law so that it can be used to disburse federal grants to states for construction of health facilities that do not qualify as “hospitals.” The administration is anxious to stimulate the building of more nursing homes, hospitals for the chronically ill, diagnostic or treatment centers and rehabilitation facilities.

An initial appropriation of \$2 million would be authorized for surveys and planning, and \$60 million annually for three years of construction. Per capita income as well as population would be used to determine a state's share, as under the present Hill-Burton program.

At the House hearing, crowded into two days, the construction program was indorsed at least in principle by every witness, except the representative of the American Association of Nursing Homes. Because the program is limited to non-profit sponsors, members of this group could not receive grants. Their spokesman said long-term loans through the Small Business Administration would help solve their problem.

American Medical Association recommended passage of the bill, but urged that facilities for the chronically ill and the handicapped be "part of or near a conventional hospital," and that facilities of all types be open to the entire community without discrimination, as in the present Hill-Burton law. (It is likely hearings also will be held on this legislation in the Senate.)

The House Ways and Means Committee, meanwhile, was giving its approval to a new income tax provision that would allow the deduction of medical expenses if they exceed 3% of adjusted gross income, rather than 5% under present law. The present maximum limitation would be doubled, and the deduction of travel expenses allowed where travel is prescribed by a physician. These changes—a long-time AMA goal—are embodied in the omnibus tax readjustment bill.

President Eisenhower's proposal for federal reinsurance of voluntary health plans has not been able to follow the steady course on which it first appeared to be embarked. At the House hearings, none of the spokesmen for the large organizations in the health fields—AMA, Blue Cross and Shield, American Hospital Association—was willing to indorse the plan. Like the AMA spokesmen, most of them wanted first to examine the actual administration bill, which at that time had not been introduced. From the Blue Cross, however, came a suggestion that the idea be tried out experimentally.

Spokesmen for national labor organizations expressed mixed reactions, with some maintaining that reinsurance was a poor substitute for what they believe the country really needs—national compulsory health insurance.

The administration's health budget for the next fiscal year, starting next July 1, calls for a slight overall reduction. The regular Hill-Burton program, currently operating on \$65 million, would get \$50 million (any appropriation to start the proposed expanded construction would be in addition). Relatively sharp reductions would be made in funds for venereal, tuberculosis and communicable disease control, in line with the policy of shifting this responsibility to the states. The various research institutes would receive about what they are now spending.

One of the few new items is for \$7.8 million, estimated as necessary for the extra cost of enlarging the federal program of vocational rehabilitation. Legislation authorizing the expansion is awaiting Congressional action. The administration hopes gradually to increase the number of persons rehabilitated annually from the current 60,000 to 200,000. While the program is being stepped up, one of its goals would be to induce states to increase their spending until eventually their appropriations match the federal. Like most of the President's health program, the rehabilitation effort has the support of the AMA.

Conferences between AMA officials and administration leaders are continuing. Latest sessions were with Secretary Hobby, concerning her department's legislative plans; with VA Administrator H. V. Higley, on treatment of non-service connected cases; and with Adm. Arthur W. Radford, chairman of the Joint Chiefs of Staff, Dr. Frank Berry, Assistant Defense Secretary for health and medical matters, and Dr. Howard A. Rusk, chairman of the Health Resources Advisory Committee, on medical care for military dependents. Representing the AMA at one or more of the meetings were Drs. Walter B. Martin, David B. Allman, Gunnar Gundersen, Louis Orr, James C. Sargent, W. L. Crawford, George F. Lull, Ernest B. Howard and Frank E. Wilson.

Earlier, AMA representatives talked over legislation with President Eisenhower at the White House.

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ADMINISTRATION'S 1955 BUDGET FOR HEALTH AND WELFARE

A. M. A. Washington Letter—No. 57

The Administration has presented Congress with its estimates of spending for medical and related programs during fiscal 1955. The Department of Health, Education, and Welfare budget alone accounts for \$2,321,591,988. It is \$200,000,000 under estimated spending for the current fiscal year, mostly because of a cut in grants to states for public assistance. The following table lists major programs of H. E. W. and medical items of other agencies, but does not include proposed armed forces spending for medical care.

	<i>Estimated Fiscal 1954</i>	<i>Requested Fiscal 1955</i>
<i>Dept. Health, Education & Welfare</i>	\$2,521,897,175	\$2,321,591,988
Public Assistance (grants to states)	1,340,000,000	1,200,000,000
Food & Drug Administration	6,280,200	6,245,000
Office of Vocational Rehabilitation	23,658,100	27,625,000*
Children's Bureau (grants to states)	30,000,000	30,000,000
Public Health Service	232,830,950	191,463,000
assistance to states, general	13,525,000	15,039,000
venereal disease control	5,000,000	2,300,000
tuberculosis control	6,000,000	3,500,000
communicable disease control	5,009,000	4,397,000
Hill-Burton hospital program	65,000,000	55,600,000**
hospitals & medical care	33,117,500	33,040,000
National Institutes of Health (operating expenses)	4,680,250	4,675,000
National Cancer Institute	20,104,775	19,730,000
mental health activities	12,039,575	12,460,000
National Heart Institute	15,169,750	14,570,000
arthritis & metabolic diseases	6,985,150	7,270,000
microbiology activities	5,721,300	5,930,000
neurology & blindness activities	4,501,750	4,763,000
<i>Veterans Administration</i>		
hospital & medical care	693,000,000	694,000,000
hospital construction	84,000,000	60,000,000
<i>Atomic Energy Commission</i>	26,000,000	27,000,000
<i>Civil Defense Administration</i>	22,500,000	60,000,000
<i>National Science Foundation</i>	8,000,000	14,000,000
<i>Bureau of Indian Affairs</i>	52,000,000	54,105,320

* Includes a \$7,800,000 item for President's program of expanded vocational rehabilitation for the disabled.

** Includes a \$5,600,000 item for start of expanded program for clinics, nursing homes.

Note: President also requested a \$1,000,000 item to start proposed reinsurance of health programs.

Annual All-Faculty Dance!

STATE-WIDE BALL TO BE PART OF ANNUAL MEETING,

APRIL 26, 27, 28, 1954



Make reservations early for the MED-CHI FACULTY BALL to be held on Monday, April 26, 1954, dancing from 9 until 1 A.M., at the ALCAZAR, sponsored by the Woman's Auxiliary to the Baltimore City Medical Society.

Be a patron, be present, be prompt!

A variety show with songs and dances entitled "MEDICANA!" will be presented at 10 p.m. Tickets may be purchased at the door. An early return of the forms below will be appreciated.

Please reserve me a table for _____ persons.

Mail to or call:

Mrs. Newland Day
3424 Guilford Terrace
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HO 7-2977

Enclosed please find my check for the patron list. Three dollars minimum patron fee. Make checks payable to the Woman's Auxiliary to the Baltimore City Medical Society.

NAME _____

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Mrs. Louis Klimes
2412 Lake Avenue
Baltimore 13, Maryland
CH 3-0220

Maryland STATE MEDICAL JOURNAL

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EDITORIAL

ON GUARD

GEORGE H. YEAGER, M.D.*

Constant vigilance on our part requires effort, energy and organization. If the medical profession is to avoid further inroads toward its socialization, the exercise of such vigilance is requisite.

There are many dynamic groups and organizations continuously working toward a goal of compulsory health insurance, which is simply a guise of socialization. Their funds are tremendous, and their efforts for utilizing and capitalizing unfavorable publicity are multiple.

There are few organizations working to counteract their propaganda and legislative efforts. The American Medical Education Foundation is developing financial resources to aid medical schools. This is an excellent antidote against government subsidization of medical schools, and deserves your support.

The Association of American Physicians and Surgeons is an organization of free American doctors that is making a continuing effort to inform doctors of the threats to the medical profession. We must remain well informed about what is being done both to the nation and to our profession. As free American citizens opposed to socialism in all forms, and as a profession whose integrity and life blood depend upon the private practice of medicine, we have a heritage that must be preserved.

The average doctor abhors and has little inclination toward practical politics. Nevertheless, counter measures, if they are to be effective, must be organized. The Association of American Physicians and Surgeons has proven effective and there is need of such a strong organization. Its strength depends upon your participation and membership.

* Editor, Maryland State Medical Journal.

Scientific Papers

HYPOTHERMIA¹

KENNETH K. KEOWN, M.D.,² BRIAN A. COOKSON, M.D., DANIEL F. DOWNING, M.D.
AND CHARLES P. BAILEY, M.D.^{3, 4}

Open cardiotomy for the correction of intracardiac pathology has long been the aim of the cardiac surgeon, physicians, physiologists and anesthesiologists. Most interested observers have felt that to obtain a bloodless field for surgery within the heart, a satisfactory heart-lung machine (extracorporeal circulation) would have to be developed.

The need of the human patient for an adequate supply of oxygen requires no further emphasis, nor does the inability of the body to maintain a reservoir of oxygen need additional accentuation.

We have been experimenting for over 12 years in the animal laboratory with various models of mechanical heart and artificial oxygenator systems. However, it has become evident to us that by means of decreasing the oxygen demands of living tissue perhaps the solution to bloodless and open intracardiac surgery can be partially achieved.

It is a fact that the elevation of body temperature by one degree fahrenheit increases the basal metabolic rate seven per cent. Undoubtedly, within limits, the reverse is also true. Reduction of the oxygen demands of the body therefore can

be obtained by lowering the temperature of the organism.

Fay, in 1938, had used controlled reduction of the body temperature to reduce established pain in patients with malignant tumors, and had attempted to retard the rate of growth of malignant tumors by this means.

McQuiston, ten years later, had overcome many of the deleterious effects of Pyrexia in children with congenital heart disease, during anesthesia and surgery by controlled reduction of the temperature.

Substantial information from Talbott's work in psychiatric patients with reduced body temperature was also available to us.

Bigelow and his co-workers have published their animal experiments with hypothermia. They have shown that a dog can survive occlusion of both vena cavae for 15 minutes at 64.4° fahrenheit, during which time it is possible to open and close the right atrium.

We decided to repeat these animal experiments, with the view of perfecting a technique suitable for application in patients with intracardiac defects.

ANIMAL EXPERIMENTS

Series 1—Sixteen dogs were used, this enabled us to become familiar with the behavior of a dog heart at low temperatures.

Series 2—Twenty-seven dogs were studied. They were cooled to 75.2°F. Both cavae of each animal were occluded for twelve minutes. Eight dogs were subjected to atriotomy. Ten

¹ Presented before the Baltimore City Medical Society on Friday, February 19, 1954, Osler Hall, Medical and Chirurgical Faculty of the State of Maryland Building, 1211 Cathedral Street, Baltimore 1, Maryland.

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³ From the Departments of Anesthesiology, Thoracic Surgery, and Pediatrics, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania.

⁴ Aided by grants from the U.S.P.H. Service and the Mary Bailey Foundation.

animals had a right ventriculotomy. Twenty-three animals survived the experiments and recovered. Ten have been sacrificed for tissue investigation, which is being accomplished now.

Series 3—Five dogs were studied with the superior and inferior venae cavae occluded for thirty minutes, and the right heart was opened for twenty minutes. Two animals survived, two animals died of uncontrollable ventricular fibrillation, one animal was accidentally killed.

Series 4—Eight animals were subjected to definitive surgery for the creation and repair of ventricular septal defects.

Series 5—Ten dogs were studied. Temperature was reduced to 78.8°F. The cavae were occluded, right atriectomy was achieved, creating an interatrial septal defect in each case. An arterial transfusion was given under constant pressure to nourish the coronary arteries, and the brain, and to prevent air embolism to the coronary arteries. The material used for the transfusion was a suspension of erythrocytes in Ringer's gelatin solution. Nine animals survived.

Series 6—Three dogs were cooled to 75.2°F. Heart and lungs were removed *en bloc* and similar organs from donor animals were transplanted. One animal survived for six hours, with return of reflexes, spontaneous respirations, and normal electrocardiogram.

The animal experiments gave us positive proof that:

(1) The circulation could safely be interrupted for twelve minutes while open cardiectomy was accomplished at a temperature of 78.8° F.

(2) It is possible to control bodily temperature by means of slow cooling.

(3) Arterial transfusions are helpful in the prevention of coronary air embolization.

(4) Citrated whole blood predisposed to ventricular fibrillation in a cold heart, due to a calcium-potassium imbalance.

(5) The heart rate and blood pressure are low-

ered in almost direct proportion to the decrease of the body temperature.

(6) Human application seems feasible.

THE INDUCTION OF HYPOTHERMIA

We believe it must be stated: 1—that anesthesia for cardiac and great vessel surgery should be directed toward the conservation of an adequate heart action; 2—that the lighter the plane of anesthesia the less depressed will be the brain, heart, liver and kidneys, and the greatest possible concentration of oxygen should be administered through an endotracheal catheter. 3—That the anesthesiologic complications most often encountered and thus the greatest challenge to prevent or overcome are:

Anoxia; hypotension; carbon dioxide retention; ventricular fibrillation; and cardiac standstill.

The preliminary medication is directed toward having the patient rested, and the oxygen demands as nearly normal as is possible to obtain.

Meperidine hydrochloride (Demerol) is ordered, with or without a barbiturate in all patients for surgery in which hypothermia is indicated and is given in conjunction with atropine sulfate 60 to 90 minutes prior to the induction of anesthesia.

In the age group less than one year of age, an endotracheal catheter of appropriate size is introduced under direct vision laryngoscopy before the infant has been subjected to a general anesthesia.

We have produced hypothermia in four infants less than 6 months of age, that have received no depressant drugs other than small doses of meperidine (one milligram per pound of body weight) without any evidence of shivering. Open thoracotomy has been performed, without evidence in the two survivors of neurological damage.

Children older than one year of age are anesthetized with intravenous thiopental sodium (Pentothal sodium) until a state of unconsciousness is reached, then the endotracheal catheter

of the largest calibre that can be inserted without trauma is passed to assure a patent air way.

Immediately following tracheal intubation a thermocouple is inserted into the rectum of the patient, and checked for accuracy by a clinical thermometer alongside the bulb in the rectum.

The dial of the thermocouple is attached securely to the anesthesia machine so that the decrease in temperature can be controlled and observed constantly. The electrodes of the electrocardiograph are applied and the patient is placed on a refrigeration mattress.

The circulating fluid used to cool the patient is started, and the temperature is lowered as quickly as is possible without the precipitation of untoward cardiac irregularities.

Cyclopropane, thiopental sodium, and oxygen are the anesthetic agents of choice in our clinic. Early in the course of hypothermia and following the original depression of the metabolic rate smaller doses of cyclopropane and thiopental sodium are required to control shivering than will be required once the circulatory and respiratory centers are depressed by the cooling process. As the depth of anesthesia is decreased shivering becomes more intense, particularly if a prolonged period of time is required to achieve the desired temperature level.

Approximately 60 to 90 minutes are required to lower an infant's rectal temperature to 74° F.

During the cooling process several events may take place. Shivering may occur. Since this increases the oxygen demand and prolongs the cooling time it must be overcome. The shivering may be occult, and appreciated only from the electrocardiographic tracing, which indicates the pattern of the "shiver waves." The addition of thiopental (pentothal) intravenously in small doses will rapidly control the trembling.

When a bodily temperature of (82.4° F.) is reached, voluntary respiratory activity ceases, then the anesthesiologist must assume control of respiratory activity. During rewarming, respira-

tions again become spontaneous at the same temperature.

The electrocardiographic tracings show progressive changes. There is a prolongation of R-R, P-R, and S-T intervals. In the majority of cases sinus rhythm is the rule at all temperatures above 23.3° Centigrade (74° F.).

The systemic blood pressure gradually decreases as the temperature is lowered. It is in almost direct proportion to the fall in body temperature.

The pulse rate after an initial acceleration becomes slower, the bradycardia obtained at (80° F.) being about one half the rate at (98.6° F.).

Immediately following the definitive surgery, rewarming is started by circulating warm water through the coils in the blanket. Patients are rapidly rewarmed to (82.4° F.) so that normal respirations may return.

The temperature is then permitted to increase slowly (87.8° to 89.6° F.). Most infants will respond satisfactorily in a recovery room, without artificial methods of raising temperature and will have a normal temperature within 10 hours.

INDICATIONS AND CONTRAINDICATIONS

Early conclusions are often proven incorrect at a later date, but at present we believe it is contraindicated to use hypothermia (1) the presence of acquired heart disease, poor myocardial tone, and defects, (2) the use of hypothermia in noncyanotic infants and children for operations not requiring the interruption of circulation.

The indications are (1) cardiac or extracardiac great vessel surgery in infants, (2) operations that require a complete interruption of the circulation, and (3) major surgery of any type in debilitated infants or children.

CONCLUSION

It has been possible to interrupt the circulation of an infant completely for as long as twenty-two minutes without evidence of renal, hepatic, cerebral, or cardiac damage.

CONTROLLED HYPOTENSION DURING SURGERY*

HRANT H. STONE, M.D.¹

The intentional decrease of the systemic blood pressure during surgery to control blood loss and decrease operative time, is not a new practice. For many years, neurosurgeons have intentionally withheld the replacement of blood lost during intracranial surgery in order to decrease the systemic blood pressure and thus establish hemostasis in a relatively bloodless field. They have also employed the sitting position for various intracranial procedures in order to decrease bleeding, promote venous drainage from the head, and pool the blood in the dependent portions of the body. In this position, blood pressure usually fell. The late Harry Koster of Brooklyn for years utilized total spinal anesthesia with hypotension as a means of performing bloodless surgery with great rapidity.

Following the second World War, interest in the use of hypotension during surgery was renewed. This was in part due to the increase in the extensive types of surgical resections that were undertaken. Such surgery required large amounts of blood replacement. The use of controlled hypotension not only greatly reduced the blood loss, but also reduced the operative time. The inability to obtain adequate amounts of blood prior to surgery and the fear of serious transfusion reactions involving the liver and kidneys, prompted others to use controlled hypotension. In this country, Gardner in 1946 advocated arterial blood letting as a means of reducing mean arterial blood pressure and secondarily of establishing hemostasis during intracranial surgery. When it was anticipated that blood loss would be brisk and difficulty might be encountered in ob-

taining hemostasis, a variable amount of blood was removed from the patient via a radial artery into which a special arterial cannula had been inserted before surgery. Arteriotomy was continued until the systolic blood pressure fell to 80 mm. Hg where it was maintained until hemostasis was ensured. Hypertensive patients were maintained at a systolic blood pressure of 100 mm. Hg. Following the completion of the intracranial dissection, the blood which had previously been withdrawn was readministered as an intra-arterial transfusion. This technic was utilized where excessive hemorrhage was anticipated. No complications or untoward effects were reported.

In 1948, the use of induced hypotension was revived in Scotland by Griffiths and Gillies. Hypotension was produced by the use of spinal anesthesia using dilute solutions of a local anesthetic drug. The usual preoperative vasopressor drug was omitted. As a result of an extensive sympathetic nerve block, peripheral resistance decreased and blood pressure was reduced. The patient was then lightly anesthetized with a general anesthetic in order to decrease metabolic rate and oxygen requirements. Oxygen in concentrations greater than that of room air was administered during the operation. The patient was then positioned with the operative site uppermost. This promoted pooling of blood in the dependent areas of the body and created a relatively ischemic operative field. It was felt that the reduction in systolic blood pressure to 70 mm. Hg using this technic was safe providing that:

1. Vasodilatation was produced by the spinal block
2. Oxygenation of the arterial blood was ensured
3. Total blood volume was maintained by replacement transfusion.

In 1948, with the introduction of a group of drugs with potent autonomic ganglionic blocking properties known as the methonium compounds,

* Presented under the title "Hypotensive Anesthesia" before the Baltimore City Medical Society on Friday, February 19, 1954, Osler Hall, Medical and Chirurgical Faculty of the State of Maryland Building, 1211 Cathedral Street, Baltimore 1, Maryland.

¹ Director, Department of Anesthesiology, Graduate Hospital, University of Pennsylvania; Assistant Professor of Anesthesiology, Graduate School of Medicine, University of Pennsylvania; Associate Professor of Anesthesiology, Woman's Medical College of Pennsylvania, Philadelphia, Pennsylvania.

hypotension could be produced without the cumbersome technic of spinal anesthesia or the uncertainties of arteriotomy. Tetramethonium, pentamethonium, and hexamethonium supplanted other hypotensive agents. The method gained a great deal of popularity in Great Britain and soon spread to this country.

The technic introduced by the English is somewhat as follows—The patient is anesthetized with an intravenous barbiturate, a curare drug, and ethyl ether. Cyclopropane is avoided because of its tendency to raise blood pressure. An endotracheal catheter is inserted to ensure an adequate airway. Hexamethonium is then injected intravenously—the dose varying with the age and general condition of the patient. The usual initial dose in the young healthy adult is 50 mgm. The reduction in blood pressure which follows in the next 3–4 minutes is noted. A systolic blood pressure between 65 and 70 mm. Hg is desired. Additional doses of hexamethonium may be needed to reach this level but often, in addition, the head of the patient must be tilted upward to obtain the desired decrease in blood pressure. The patient is then positioned with the operative site elevated. This promotes drainage of blood away from the operative area and produces a relatively bloodless field. During surgery, the blood pressure is maintained at this low level. Blood loss is poorly tolerated and must be replaced immediately. The return of the blood pressure to the normal preoperative level must be slow to prevent secondary hemorrhage. The use of vasopressor drugs postoperatively is generally avoided. During the postoperative period, the patient is kept horizontal and observed closely. The duration of ganglionic block with these agents is 3 to 4 hours. Recently a new autonomic ganglionic blocking drug known as Arfonad has been used in place of hexamethonium. This drug, a thiophanium compound, produces ganglionic block of short duration which permits a more controllable type of hypotension.

Hypotension produced by a decrease in effective circulating blood volume as seen in surgical

shock and also controlled arteriotomy, is vastly different in its effects on tissue circulation, than is hypotension produced by a block of the autonomic ganglia. With decreases in blood volume, peripheral vasoconstriction occurs with a reduction in peripheral blood flow. However, with the use of sympathetic blocking agents, peripheral vasodilatation selectively occurs which, to a certain degree, maintains tissue blood flow.

The ultimate detrimental effect of a reduced mean arterial blood pressure depends upon the insufficiency of blood flow to certain critical organs such as the heart, brain, liver and kidneys. The blood flow to an organ depends upon the mean arterial blood pressure and the vascular resistance to the flow of blood within that organ. During hypotensive periods, there is a concomitant decrease in vascular resistance which roughly parallels the decrease in mean blood pressure. The ability of the body to make a satisfactory compensation in terms of maintained organ blood flow depends upon the following factors:

1. *The Duration of the Hypotension:* Short periods of hypotension are tolerated better than prolonged ones. Is there a deterioration of effective compensation with maintained hypotension? Bunschwig has suggested 1½ hours as the maximum duration of the hypotensive period. It remains for the clinician who employs induced hypotension to determine the safe duration of its use. Thus far a safe period of hypotension cannot be defined.
2. *The Degree of Hypotension:* It has not been established that vasodilatation can parallel extreme reductions in arterial blood pressure with maintenance of organ blood flow. When the decrease in mean arterial blood pressure goes below the critical pressure necessary for the blood flow to a specific organ, circulatory insufficiency will result no matter how complete the vascular dilatation within that organ. Hampton and Little, in a survey of

the complications of controlled hypotension, demonstrated a significant increase in the incidence of complications when systolic blood pressure was maintained below a level of 80 mm. Hg.

3. *The Condition of the Blood Vessels:* Especially those of the heart, brain, liver and kidneys. If these vessels are sclerotic and inelastic, dilatation in response to hypotension cannot occur. This is the unknown quantity with individual variation which makes the ultimate effects of induced hypotension unpredictable. Therefore, before hypotension is used, some attempt must be made to evaluate the degree of circulatory elasticity present.
4. *The Metabolic Needs of the Tissues During Hypotension, Especially Those of the Heart and Brain:* Lower cellular oxygen demand will permit greater reductions in blood flow without ill effect. Metabolism is lowered by preanesthesia medication, general anesthesia and lowered body temperatures (refrigeration). Spinal anesthesia, by its reduction in peripheral resistance and cardiac output, reduces the work of the heart and hence the demand for coronary blood flow and oxygen. It is possible that the heart is not damaged during moderate hypotension if the coronary vessels are capable of dilatation.
5. *The Production and Liberation of Specific Depressant Substances Arising from Ischemic Tissues:* Shorr has demonstrated the production of such a substance in the liver of shocked animals. Does such a substance play any part in the prolonged postoperative hypotension frequently seen following the clinical use of induced hypotension? Perhaps other toxic products are also liberated which adversely affect body physiology.

The effect of the reduction in mean arterial blood pressure by hexamethonium on the circulation of the heart, brain, liver and kidneys has

been experimentally studied. These results are briefly presented.

1. Effect of hexamethonium on cerebral circulation.

Recent investigation has demonstrated that with a reduction in mean arterial blood pressure of 47% there was not a significant reduction in cerebral blood flow. Cerebral metabolism was not changed. A 46% decrease in cerebral vascular resistance maintained the cerebral circulation. It is not to be implied that similarly effective compensation always accompanies greater blood pressure reductions.

2. Effect of hexamethonium on cardiovascular system.

In patients without congestive heart failure and whose cardiac outputs were in the normal range, the hypotensive response to hexamethonium was accompanied by a decreased cardiac output and little or no change in total peripheral resistance. Fall in blood pressure with hexamethonium was due to a decrease in cardiac output on the basis of a decreased venous return. This is verified by a uniform reduction in pressure of the right side of the heart. Fall in blood pressure with hexamethonium is not entirely due to a reduction in peripheral resistance.

3. Effect of hexamethonium on hepatic-portal blood flow.

Despite a moderate reduction of hepatic vascular resistance, estimated hepatic-portal blood flow usually falls after hexamethonium.

4. Effect of hypotension on renal blood flow.

Renal plasma flow decreases paralleling the initial fall in arterial pressure and then rises to approximate control levels despite a continued hypotension. The kidneys appear to be more resistant to the effects of hypotension than are other critical organs.

Many complications have been reported incident to the use of controlled hypotension and probably reflect a deficiency in organ blood flow during the hypotensive period. The incidence of these complications is very difficult to establish on a cause and effect basis. Too many complex factors could influence their development. It is important to point out that the incidence of complications is significantly greater when the level of the systolic blood pressure is maintained below 80 mm. Hg. From the results of a survey of 21,000 cases where induced hypotension was used, 46 deaths attributable to the method were reported or an incidence of 1 in 459 cases. The incidence of complications was vastly higher (549) or 1 in 38 cases.

Induced hypotension may be used prophylactically (to reduce blood loss) where excessive amounts of blood loss are anticipated during surgery or it may be used as a therapeutic tool to arrest otherwise uncontrollable hemorrhage which has occurred.

Since the majority of the complications encountered are referable to derangements of function of the brain, heart, and kidney, it might appear unwise to use controlled hypotension in aged, sclerotic patients who give a history of coronary, cerebral or renal insufficiency.

While the concept of the control of operative bleeding by induced hypotension is old, its possible acceptance as a routine procedure is

guarded. The question that must still be answered is "How safe is induced hypotension"?

No one can question the value of induced hypotension during surgery. Uncontrolled hemorrhage may jeopardize the life of the patient, it prolongs operating time and prevents the completion of a proposed operation. It has had many clinical trials with excellent results. The reports are encouraging. However it is difficult to alter our concept of thinking in terms of normal blood pressures. Too long has the importance of adequate pressure head been stressed to suddenly have it abandoned. It must be recognized that hypotension is potentially dangerous and the indication for its use must outweigh its serious implications. The decision to use controlled hypotension should be made by the surgeon not the anesthesiologist. It should be employed as a surgical adjunct with full knowledge that it violates the cardinal surgical teaching of hemostasis. The ultimate acceptance of this technic must await the test of time with the accumulation of evidence demonstrating a lower incidence of mortality and morbidity when it is employed. Would it not be preferable to employ less drastic reduction in blood pressure producing a modified hypotensive technic which could permit *relatively* bloodless surgery with a greater margin of safety than to rely upon acute reductions of blood pressure which are potentially dangerous?

* * * * *

ANNOUNCEMENT OF REGULAR CORPS EXAMINATION FOR MEDICAL OFFICERS

United States Public Health Service

A competitive examination for appointment of Medical Officers to the Regular Corps of the United States Public Health Service will be held on June 1, 2, and 3, 1954. Examinations will be held at a number of points throughout the United States, located as centrally as possible in relation to the homes of candidates. Applications must be received *no later than April 30, 1954.*

FORMS OF PURPURA¹

Diagnosis and Treatment

MILTON S. SACKS, M.D.²

In the brief time available, one cannot cover in too adequate fashion the many aspects of purpura. I should like therefore, after a brief classification, to concentrate on the results which we have obtained during the past two years with the use of Cortisone, either alone or in combination with splenectomy, in thrombocytopenic purpura.

The physician faced with clinical manifestations of subcutaneous hemorrhage and/or mucous membrane bleeding of various sorts, must differentiate as early as possible the thrombopenic and the non-thrombopenic forms. The platelet count is the basis of this differentiation. The trained observer may form an accurate opinion by inspection of a good blood smear; this can be amplified by quantitation. Other diagnostic features of thrombocytopenic purpura include prolonged bleeding time, increased capillary fragility, and impaired clot retraction.

Of the non-thrombopenic forms the chief one is Henoch-Schonlein, or anaphylactoid purpura, which is characterized by the following syndrome: petechial and purpuric lesions of the skin, transitory joint swellings and bouts of colicky abdominal pain, frequently associated with the presence of blood in the stools. All of these features may not be present in every case. This is a rather interesting form of purpura. Although much has been added to our knowledge of this syndrome in recent years, its basic mechanism remains unknown. The difficulty appears to be an immunological one and hemorrhage is due not to coagulation defects but to vascular pathology. Other forms of non-thrombopenic

purpura exist, but are of lesser significance and will not be considered here.

Our next major consideration will be forms of thrombocytopenic purpura. These cases are classified as either primary or idiopathic thrombocytopenic purpura or secondary thrombocytopenic purpura. Since management of these two groups is quite different, careful distinction is essential.

Secondary thrombocytopenic purpura may be associated with some other blood dyscrasia such as aplastic anemia or a myelophthisic process in which there is invasion of the bone marrow by malignant cells of various types. One must always be sure that there isn't some other underlying blood dyscrasia of which the purpura is merely one manifestation. The removal of the spleen in such cases may have very serious and tragic consequences. Secondary thrombocytopenic purpura may also be due to drug toxicity and it is of considerable importance to get a complete history with regard to the ingestion of various drugs. Among the common offenders in recent years has been quinidine. We have seen a number of cases of thrombocytopenic purpura following the administration of quinidine for the correction of a cardiac arrhythmia.

Recently, also there have been a number of reports of thrombocytopenic purpura following the use of butazolidine, and other cases have apparently been associated with the administration of chloramphenicol and streptomycin. Gold salts, arsenicals, sulfonamides, etc., have also been incriminated from time to time. I merely mention a few to emphasize the importance of obtaining a careful history in regard to the administration, or self-ingestion of various drugs.

Many of the purpuras of the secondary variety will promptly improve upon discontinuance of the drug and the administration of Cortisone

¹ Presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, Wednesday Morning, April 29, 1953, Osler Hall, Baltimore, Maryland.

² Associate Professor of Medicine and Director of Clinical Pathology and Rh Laboratory, University of Maryland School of Medicine.

over a short period of time. Some may result in permanent bone marrow damage with a resultant aplastic anemia.

Finally we come to the group which I would like to consider more fully today, namely, idiopathic thrombocytopenic purpura.

This is a disease predominantly of children and young adults. When one examines statistics collected from the literature, it is apparent that approximately seventy-five per cent of these cases occur within the first three decades of life. One cannot, however, rule it out in elderly people. In fact one of the cases in the series which I am going to present today, was eighty years of age.

The etiology of this disease is still not known, although within the past two years important advances have been made. Harrington and his co-workers at Washington University, in St. Louis, demonstrated that there was present in the circulating blood of these patients a factor associated with gamma globulin, presumably an antibody, which is capable of agglutinating and perhaps destroying platelets.

This factor is transmissible from one human to another. Experiments were carried out with blood from patients with idiopathic thrombocytopenic purpura. This was transfused into normal compatible individuals who then promptly developed purpuric manifestations and a low platelet count which persisted for perhaps one to two days and then gradually returned to normal. It was thus demonstrated that it was possible to passively transfer the disease for a brief period.

Another demonstration of this passive transfer is seen in pregnant women with idiopathic thrombocytopenic purpura, who occasionally give birth to babies with congenital thrombocytopenic purpura. The disease lasts only for one to two months in the infant and then disappears. In other words, this globulin factor is capable of passing across the placental barrier.

The factor may persist for many years in the blood of the patient even after removal of the spleen. It is felt that the spleen is not an impor-

tant site of formation of this particular factor and that the removal of the spleen which has been done for some forty-five years now, merely removes the major site of destruction of platelets.

Until recently there have been two major approaches to the treatment of this disease. One was the so-called conservative management, and the other, splenectomy. Conservative management meant doing nothing. The reason for such an approach was based upon the fact that many of these patients underwent spontaneous remission if one waited long enough. The patient was put to bed and transfusions were given if necessary. Blood has no curative properties as far as this disease is concerned. It merely replaces red cells and hemoglobin if needed. There was no specific drug therapy. If the patient got well within a period of a few weeks or a month or two, this was hailed as a triumph of conservative therapy. Actually it was spontaneous improvement in the disease itself. If the patient did not respond, splenectomy was the next thing. Splenectomy was not always the answer either, because a definite proportion of patients failed to respond even to splenectomy.

A more careful analysis of this disease reveals that it follows a different pattern in children as compared to adults. The incidence of spontaneous remission is quite high in children and comparatively low in adults. The incidence of serious internal bleeding, particularly cerebrovascular accidents, is low in children but considerably higher in adults.

Three clinical varieties of idiopathic thrombocytopenic purpura are recognized. The acute form which runs its course within a few months frequently improves spontaneously. If symptoms persist beyond three months, the case may more properly be called chronic thrombocytopenic purpura. There is also a recurrent form in which the patient who spontaneously improved or was splenectomized, has a recurrence months or years later.

I should like to present to you an analysis of

results which we have obtained in the past two years in the treatment of seventeen cases of idiopathic thrombocytopenic purpura, either with Cortisone alone, or with Cortisone and splenectomy. In the series of seventeen cases, there were nine children and eight adults. The age range in the young group was two to five-and-a-half years. In the adult group, patients ranged from eighteen to eighty years of age. There were thirteen females and four males (a ratio of three to one). In the literature generally, the considerably higher female incidence is also quite striking. This may be of some etiological significance. It is of interest to note that fifteen of these patients were white and only two were negroes. The disease is comparatively rare in negroes.

Ten patients in this group had a complete recovery and have now been followed for almost two years without recurrence. These patients were treated only with Cortisone. It will be noted that eight of the ten were children and only two were adults. The latter were young women eighteen and twenty years of age respectively. One fact that immediately stands out is that Cortisone seems to be of value mostly in the younger patients with idiopathic thrombocytopenic purpura.

Only one child in the group of nine children had to be splenectomized. This child was followed for almost a year. She had a spontaneous recovery on Cortisone. Cortisone was discontinued; the disease recurred. Again Cortisone, and again recovery; again taken off drug, and again relapse. It became apparent that we were dealing with chronic thrombocytopenic purpura, and that it was not wise to continue Cortisone indefinitely in a growing child. Therefore she was splenectomized and has had an excellent recovery.

Four of the adults have been splenectomized and one additional patient should be splenectomized, but has left town with her family. We see therefore that five patients in this group recovered either through the use of Cortisone, pre- or post-operatively and splenectomy. The mortality

rate in this group of seventeen, was 6%; only one patient died, a male aged eighty years.

Some data regarding the use of Cortisone will next be considered. The average duration of symptoms prior to use of the drug was about sixteen days. Remission was observed approximately within one week after starting Cortisone. Prior to the use of Cortisone the best available figures demonstrated about sixty per cent remission rate within one month, and about eighty per cent within a period of three months, in *children*. In the group presented today eight of nine children underwent remission within twenty-three days after the onset of symptoms. It is possible that if the patients had sought medical attention earlier, the average duration might have been even shorter. Approximately 0.75 gm. of Cortisone was required on the average to produce a remission and a total dose of about 2.4 grams was given during the entire course of treatment. To date it appears that remission is complete and relatively permanent.

Certain interesting features of a few of the adult patients are worthy of note. One patient, a female aged 40 years, had a remission with Cortisone therapy, but relapsed when the drug was discontinued. Cortisone was again used with success and the patient was splenectomized while still on the drug and in remission. In other words, she went to surgery at an optimum time as far as bleeding tendency was concerned.

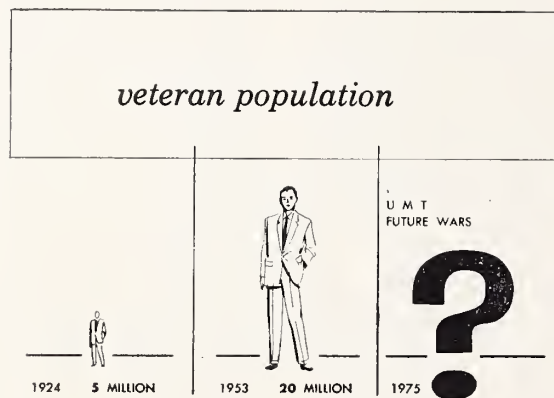
Another patient, a fifty-four year old man, failed to respond to Cortisone and was splenectomized. His platelets did not rise after splenectomy. He was followed for a period of several weeks during which time there was recurrence of bleeding manifestations. In pre-Cortisone days, one would have had to wait and hope for the best. It is interesting to note that although this patient did not respond pre-operatively, when given Cortisone post-operatively his platelets rose to a normal level and have been maintained now for about ten months without difficulty.

A further case of interest was a pregnant female who was first diagnosed in the twelfth week

of her pregnancy. Thrombocytopenic purpura and pregnancy do not go well together. The administration of Cortisone resulted in a prompt remission of the disease. The dose was tapered off because of possible effects on the fetus, and we see a variable platelet count. She was kept on Cortisone until delivery. The delivery was perfectly normal and resulted in a child who had thrombocytopenia but no bleeding. Within two months the infant's platelet count rose to normal and has remained so ever since. Following delivery, the patient herself was taken off Cortisone and has relapsed. She is now a candidate for splenectomy.

In summary, then, the conservative management of thrombocytopenic purpura has begun to assume some definite meaning other than watchful waiting and hoping for spontaneous remission. The use of Cortisone has definitely changed the outlook in regard to treatment of this disease in children. In adults, the use of Cortisone has not been quite as successful but in some cases it has converted a patient with a serious bleeding tendency to one with a better risk as far as surgery is concerned. Finally, Cortisone seems to have value in the treatment of recurrent cases of thrombocytopenic purpura following splenectomy.

In Viewing the VA Medical Program . . .



The U. S. veteran population now includes about 40% of all adult males. Under existing legislation, the federal government is obliged to provide "free" medical care for many of these veterans, if they request it. The medical profession questions the soundness of providing medical care at federal expense to veterans with non-service-connected disabilities. It is likely that by 1975 the U. S. will truly be a "nation of veterans." If the VA medical program continues to accept responsibility for the care of veterans with service-connected and non-service-connected disabilities alike it is difficult to see how a complete federal health program can be avoided.

ARTICLES OF INTEREST

GEORGE HENRY RIGGS, M.D.^{1,2}

Back for a visit in his native County where he spent more than sixty years in active medical practice, is a slight, kindly faced, white haired gentleman, now near his eighty-fourth birthday, whose name in professional circles is synonymous with conservative, constructive care and treatment of the mentally ill.

Dr. George Henry Riggs was born June 20, 1870 in Ijamsville, to become one of the country's early psychiatrists and founder of Maryland's third oldest institution for nervous and mental diseases. Today, under new ownership, the Riggs Cottage Sanitarium still retains the founder's name.

Now retired, Dr. Riggs divides his time between the homes of a son in Washington and a daughter in Arlington, Va. Even out of practice, the veteran doctor is well remembered and occasionally consulted by some former patient who prefer the mature opinion of the older man to that of some "youngster" of no more than twenty or thirty years' experience.

PSYCHIATRY LITTLE KNOWN

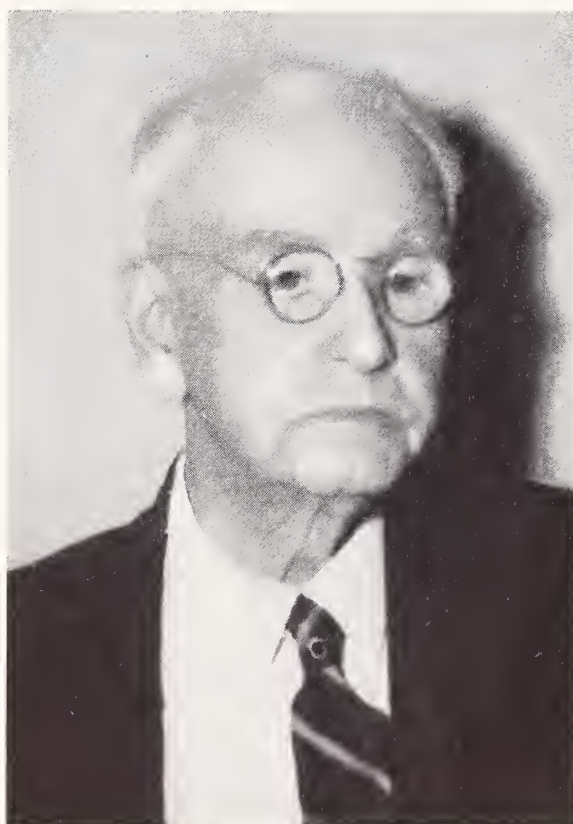
In 1896 when Dr. Riggs opened his Ijamsville Hospital, neuropsychiatry was in its infancy, unrecognized as a medical specialty, yet many techniques claimed by present-day physicians as "modern" were developed and used in the Cottage Sanitarium half a century ago. Much has been made in recent years of the "discovery" of the therapeutic value of music, but before the turn of the century Dr. Riggs observed patients' happy response to piano recitals by Mrs. Riggs, and to dancing. Concerts and dances became an important part of hospital routine.

Mrs. Riggs also conducted occupational therapy classes, then a startling innovation in the care of mentally affected patients.

For generations the Riggs family has been a prominent one. Christopher M. Riggs, father of the physician, was a thrice elected member of the state

legislature, and through his mother, Angeline LaBarre Riggs, Dr. Riggs is descended from a French officer, Capt. Lorenzo LaBarre, who came to America with LaFayette, and remained here after the victorious end of the Revolution.

Dr. Riggs' own lifetime has spanned revolutionary changes in medical concepts, education, and practice. He is one of the few survivors who "read medicine" with an established practitioner before college matriculation. For two years young George Henry Riggs was a student in the New Market office of Dr. Jesse M. Downey, distinguished family doctor. Prior to that he attended public schools in Frederick County and Baltimore City, and spent six years at the Glen Ellen Academy at Ijamsville. In 1891 he was graduated from the University of Maryland Medical School, a classmate of the late Dr. E. C. Kefauver. His first office was in Frederick with Dr.



GEORGE HENRY RIGGS, M.D.

¹ Reprinted by courtesy of The News, Frederick, Maryland, 2-12-54, and written by its feature writer, Mrs. Betty Sullivan.

² Contributed by A. Austin Pearre, M.D.

Franklin B. Smith. A year later he went to Relay as associate resident physician at Conrad's Sanitarium, oldest private treatment center in Maryland for mental and nervous diseases.

FIRST SANITARIUM PATIENT

An attack of typhoid fever in 1896 brought Dr. Riggs home to recuperate, and while he himself was a shaky convalescent, a physician friend in Washington, impressed by the young doctor's success with mentally ill patients at Relay, and charmed with the pleasant Ijamsville countryside, saw the combination as the ideal solution to a problem. He implored care in the Riggs home for a young friend seriously ill of a nervous disorder. Almost immediately this first patient was joined by a second, and a third, and youthful Dr. Riggs found himself head of an embryonic sanitarium. State licensure hurried development of the new hospital which soon had filled its capacity of 27 patients. At first both men and women were treated but lack of male nurses in World War I, forced Dr. Riggs to limit admission to women patients, and so the Cottage Sanitarium functions today.

The buildings purchased by Dr. Riggs from his family, were actually cottages, three of them, 35 x 35 feet square, separated by fifty feet, and sprawled along the crest of a low hill. They'd been built of Maine timbers in 1862 by the Maryland Slate Company for Welsh laborers in the adjacent slate quarries, now long abandoned.

Dr. Riggs' plan of linking the original cottages by connecting structures to provide kitchen, during room, sun parlor, and additional bedrooms proved satisfactory for the years and in 1954 the Sanitarium proper, now owned and administered by Dr. Joseph Lerner, of Pennsylvania, is in the same pattern the local physician devised in 1896. Dr. Hosea McAdoo, who purchased the Riggs Cottage Sanitarium in 1939, changed and remodeled barns, houses for employees, and other buildings.

PATIENT SEEN AS HUMAN BEING

In July, 1896, Dr. Riggs married Cordelia, daughter of Benjamin and Anna Eichelberger Duvall, and as a team they planned and worked for the new Sanitarium. Mrs. Riggs supervised the kitchen, devised special diets, and assisted her husband in administrative detail.

To Dr. Riggs every patient was a human being

to be seen and treated as an individual. Today's physicians have adopted that concept and call it "ultra modern," yet this early psychiatrist held steadfastly to his conviction that every sick person must be studied as a whole personality, not merely as a conglomeration of clinical symptoms and laboratory reports.

LIFE WITHOUT VACATIONS

From the day he started practice until his retirement after he was eighty, Dr. Riggs never took a vacation, but managed to crowd into his busy life successful practice in two phases of medical work. As psychiatrist he treated 1,030 patients at the Sanitarium and simultaneously during the more than forty years he conducted that institution, he did general practice as a horse-and-buggy country doctor. He has records of more than a thousand babies delivered and today, as he strolls the streets of Frederick, it is nothing unusual for a stranger to stop and shake his hand and say: "You brought me into the world, Dr. Riggs."

From all his recollections of medical practice, perhaps the 1918 influenza epidemic is most deeply and dramatically etched on the doctor's mind. Deferred from military service in World War I, as essential in his home community, Dr. Riggs was the only doctor in the Ijamsville area when "flu raged." Days and nights took on nightmare character. Too worn out to drive the car, the physician was transported by alternating chauffeurs in two automobiles while he made as many as 40 home visits a day, saw 30 more office patients, and kept up his hospital routine.

On one home visit Dr. Riggs found not one but fourteen patients in the house. He learned to go virtually without sleep himself, to protect himself by wearing constantly a surgical mask over nose and mouth, and to try to allay the panic wrought by the epidemic.

SANITARIUM SOLD TO DR. MCADOO

In August, 1939, Dr. Riggs sold the Riggs Cottage Sanitarium to Dr. McAdoo who, with his wife, Dr. Julia Kagan, operated it until last summer when it was purchased by Dr. Lerner.

Mrs. Riggs died June 16, 1940. For three years Dr. Riggs did general practice in Frederick City. Then for a time he had offices in Bethesda where the wartime shortage of medical care had become acute.

Later, married to Elizabeth Downey Stone

Gillelan, daughter of the physician with whom long ago he had "read medicine," Dr. Riggs went to Emmitsburg to live and to do general medical practice. The second Mrs. Riggs died suddenly of a heart attack January 23, 1950.

Dr. Riggs never has forsaken his conservative approach to problems of mental and nervous illness. Modern tensions result, he feels, from the pitch of excitement in which people live, from their irregular hours, and from an increasing reliance on alcohol. He believes, "the important thing is to build up the general resistance of the patient, to use reconstructive, reeducational therapy until we find that is not sufficient." Only if conservative therapy fails, does he see justification for recourse to drastic measures.

Dr. Riggs is a past-president of the Frederick County Medical Society of which he is a life member, and holds life memberships in the Medical and Chirurgical Faculty of Maryland, the American Medical Association, the Maryland Psychiatric Society and the American Psychiatric Association.

He is a former member of the Southern Medical Association, the Tri-State Medical Society of Maryland, Virginia and the District of Columbia, and of the Clinical Society of Maryland. He also is past master and life member of Philanthropic Lodge 168, AF & AN, New Market, and of the Masonic Veterans Association of Maryland. He was on the executive staff of Frederick City Hospital for 25 years and was a lecturer to students in nurses training school.

JOURNAL REPRESENTATIVE LUNCHEON

TUESDAY, MARCH 31, 1953

FACULTY BUILDING

GEORGE H. YEAGER, M.D., EDITOR AND CHAIRMAN

Speaker—MRS. KATHERINE TYSON

Editorial Board—

DR. J. TYLER BAKER, Easton, Talbot County
DR. HUGH J. JEWETT, Baltimore City
DR. EMIL NOVAK, Baltimore
DR. JOHN A. WAGNER, Baltimore

Journal Representatives—

Dr. Conrad Acton, Baltimore City Medical Society
Dr. Richard C. Dodson, Rising Sun, Cecil County

Dr. Jesse S. Fifer, Frederick, Frederick County
Dr. W. H. Foard, Manchester, Carroll County
Dr. Louis G. Llewellyn, Pocomoke City, Worcester County
Dr. G. William Martin, Jr., Queenstown, Queen Anne's County
Dr. Theodore R. Shrop, Ellicott City, Howard County
Dr. Donald L. Somerville, Towson, Baltimore County
Dr. O. D. Sprecher, Hagerstown, Washington County
Dr. L. M. Cuvillier, Jr., Silver Spring, Montgomery County
Dr. John M. Warren, Laurel, Prince Georges County
Dr. Louis S. Welty, Easton, Talbot County

Dr. George H. Yeager: By way of background, I simply want to explain that this meeting is an innovation, just as the Journal was an innovation about a year ago. We have been extremely anxious to meet with the County representatives, particularly with reference to the material they are submitting for publication to the Journal.

When we established the Journal, we established it with the primary hope that it would appeal to the county membership, to the doctors in general practice, and that there would be more satisfactory contact between the state headquarters and the general membership. Most journal representatives have expressed the hope that they could meet and discuss in more or less round-table fashion their problems. They also hoped to meet the Editorial Board and exchange ideas as to what should be published in the Journal and what type of Journal we should develop.

Dr. Chatard, who unfortunately cannot be here because of illness sends his regrets.

We have had a Journal for about a year. In the position of editor it is difficult for me to decide whether the Journal is well liked and whether it is a popular publication to the membership. Maybe I have been misled. Most people who have discussed it with me seem to be quite pleased and seem to feel that it has fulfilled a needed purpose with the membership.

I am now going to ask Mr. Kirkman to discuss the finances of the Journal.

JOURNAL EXPENSE—MR. KIRKMAN

Mr. Kirkman: When the Journal was first taken under consideration, it was thought we might have a publication of approximately forty pages of which twenty might be technical and twenty might be ads; perhaps to come out every other month or quarterly. We soon found out that that was erroneous for two reasons. In the first place, a Journal limited to twenty pages for technical and departmental items would not be a creditable organ of information.

And then, since we are dependent upon income from advertisements, we found that national advertisers would not be interested in a bi-monthly or a quarterly publication; they wanted one beginning with the calendar year. This upset our schedule a little bit and meant that we started the publication January 1, before we really had completed the groundwork and made preparation for carrying the editorial and clerical work.

However, we got started and it soon became apparent that the original concept of the size was erroneous and so that has been expanded as you know, and now we run a journal anywhere from seventy to ninety pages.

Now I think Dr. Yeager is interested in the cost for this reason. When the Council decided upon the publication of the journal it was known that it would be difficult to obtain enough revenue from the advertisements to fully finance the project, and so it was decided to allocate a dollar-and-a-half of the members' dues toward the publication. It has worked out like this. We estimated originally on twenty-six hundred copies. The circulation has increased by demand, so that now we publish twenty-nine hundred copies and it has gone as high as three thousand.

We have had excellent cooperation from the Advertising Bureau of the American Medical Association which is a bureau maintained by the AMA for the purpose of securing advertising contracts for all state journals. The cost of maintaining this bureau is prorated against the various state journals so that the cost is not taken from the dues of the members of the AMA. They have succeeded in getting us advertising which amounts to about twelve hundred dollars a month, and then we are getting some local ads which are more than we anticipated but not enough to do what we want to do. In other words, we have a total income of around fourteen hundred dollars from ads, a month.

Now I want to pause right there and ask the men, particularly from the Counties, if they can obtain information about any local concerns who might be interested in advertising. I would like to know about it and I'd be glad to follow it up. We do need some more advertising income to the extent of two or three hundred dollars a month, to do what we want to do.

Every month Dr. Yeager, Miss Wynde and myself, have a Council of War about the amount of material we can publish. There seems to be a wealth of very excellent material that Dr. Yeager would like to get before the members. But he is restricted by the amount of money that I have available, for after all, we have to pay our bills.

Now it costs about fifteen hundred dollars a month to print the Journal. We have one of the best printers in this section of the country. The Waverly Press, as you know is associated with Williams & Wilkins. They are publishers of scientific journals and books, so I think you will find the quality of printing and the format is excellent and cannot be improved upon.

Hardly a month goes by, but we get some letter from the Advertising Bureau of the AMA calling attention to inappropriate or bad printing. It never applies to the Maryland State Medical Journal.

The fifteen hundred dollars a month, is the printing cost, and in addition we have other expenses such as the services of a proof-reader who was formerly with the Waverly Press, and is experienced in reading proof of scientific articles.

Then, in order to obtain some very good material, we use a reporter at the meetings of the Baltimore City Medical Society and we have to pay for the transcriptions of that, of course. But that has been the source of a number of very excellent articles.

So the incidental costs run about two hundred dollars a month, which make the total cost about seventeen hundred dollars a month as compared with the advertising income of fourteen hundred dollars. So that it costs us, out of our dues

money, three hundred dollars a month; thirty-six hundred dollars a year, which for twenty-four hundred members is just a dollar-and-a-half that we estimated at the beginning.

By holding the journal to its present volume in content, we are balancing the budget pretty well, but if it is possible to secure additional advertising revenue, it will be possible for us to expand the Journal in some departments and I think it will be more readable, more interesting and more informative. I'll come back to my thesis that if any of the members can help me out by securing some local ads, we will greatly appreciate it and even give them fifteen per cent commission which is the advertising agencies' commission.

Dr. Wagner: There are two ads we cannot accept, whiskey and contraceptives.

Mr. Kirkman: Well, the Council of the AMA reversed itself on whiskey advertising. However, we haven't been able to get any. Maybe our members don't buy enough to interest the distillers. We did have what we thought was a very lucrative ad. Under pressure from the AMA they sent a whiskey ad for the Journal of the AMA. It was not sensational advertising of the type you see in the popular magazines but rather dignified, and we said we would accept it. However we never received it.

Of course in reference to drugs and food products which are nationally advertised we are limited under our agreement with the Advertising Bureau of the AMA to those products which have been approved by the Council on Pharmacy and Chemistry of the AMA, or the Council on Foods and Nutrition. This limits us somewhat. It isn't too easy to get ads especially for a journal like this, especially locally.

I've been refused consideration on two occasions by the Board of Directors of the Retail Merchants Association. I could get some Department Store ads if it weren't that they are tied up with their own organizations and they disapprove all specialty journals. They say if they want to sell dresses, shoes or hats they want to put their money in the newspaper where they can talk to a million-and-a-half people, not to twenty-six hundred doctors. So it is rather difficult to get local ads, and that is where I am pretty well stumped.

The AMA has done what they promised to do when they had this under consideration. They have given us about the number of pages of ads they promised and we have gotten more locally than we expected to in the beginning. But there is a tremendous field if we had somebody to work it up and make solicitations.

I think that is all I have at the moment. (APPLAUSE)

Dr. Yeager: Are there any questions anyone would like to ask Dr. Kirkman?

From Audience: Would it help if we all switched to Camels?

Dr. Wagner: We have Camels and we have Phillip Morris.

Question: As I understand it, the large newspapers for instance print a certain portion of their material on rag paper and a certain portion on pulp paper, the idea being that rag paper is much more expensive. I would venture to say that not more than ten per cent of these journals that are published and sent around the counties are saved any length of time. Those which are sent to libraries etc., should be on a fine grade of paper. It seems somewhat of a waste for very

fine, fancy paper to be sent to someone who is going to discard it in the waste basket or give it to the nearest hospital so that the hospital has seven copies or so. And it seems to me you might be able to save some money on paper where a printer would give you a better rate on cheaper paper—say four-fifths of your edition. Something like that?

Dr. Kirkman: I don't believe it would save a great deal because it means you have to stop the run and change the paper. The time consumed in making that changeover, offsets the cost of paper. The cost in printing is composition. Now this kind of composition runs from ten to twenty dollars a page. The average cost per page including ads is seventeen dollars. Small type and particularly in tabular form will run up to twenty dollars a page. The average is twelve or thirteen dollars per page just for composition, and the completed journal has been averaging seventeen dollars per page. So you see the paper—and it is a finest grade of paper (you are perfectly right)—is not a very significant part of the cost. It's the composition. And of course, the color is important. Color work is thirty-five dollars a page extra and we don't make any money on colors.

Dr. Yeager: I believe if we should publish ten or twenty per cent of our journal pages on a good grade of paper, then another percentage on another grade, it would pose quite a problem.

Question: What about national distribution to various medical schools and libraries?

Dr. Yeager: There is an exchange that is quite extensive. Most of it is an exchange, journal for journal. Some of the savings to the Faculty have been indirect. Many of the journals that we formerly had paid for are now being received on an exchange basis. The library reflects a saving from that viewpoint.

Are there any other questions? (None) Thank you very much, Mr. Kirkman.

Dr. Yeager: Through the efforts of Dr. John Wagner, Mrs. Katherine Tyson has very kindly consented to come here and talk to us today. Mrs. Tyson diffidently requested suggestions with reference to her subject material. I told her that I have heard repeatedly that medical writing is unforgivably dull. I believe the majority of it is. If she wants to start on that premise I'm quite sure we can all stand up to her criticisms.

I believe that her criticisms will be constructive. I'd like to reiterate that if we can have interesting items and interesting news from the counties, we will have a much more worthwhile journal.

By way of introduction, I'd like to read this statement about Mrs. Tyson.

"In addition to being an accomplished publicity and public relations executive, she is also an extremely versatile script writer, a feature writer, and she has authored several documentary series for WBAL and has put them on the air—notably one on geriatrics—'The Years Ahead' which was produced in 1951.

She is also an actress and has taken part in several of the series which she wrote. She was in charge of a recent TV show which was put on the air from the University Hospital. And I might say in addition to those minor accomplishments,

she is the mother of four children. So in her spare time she has many domestic responsibilities."

Mrs. Tyson: Thank you, Dr. Yeager.

Until yesterday, I didn't know what the inside of a medical journal looked like and then around eleven o'clock last night—I had all my other writing finished—I started to read, and read till about three. So now I know some of you. In fact, when I came in I asked if Dr. Somerville were here because his writing struck me as being particularly fine, and I'm glad to see that he is here so that I can tell him in person.

Dr. Wagner asked me to speak on "How to gather and assemble the news." Let me start with the story about how not to gather the news; it is true and rather funny and I think you will appreciate it.

Some years ago there was a reporter at the News-Post who was also very fond of the bottle. In New Jersey a woman was murdered and this reporter was sent to cover the story. Well, he bought himself a bottle for the train trip and when he arrived at his destination the first place he sought was a local "Pub." He was having a grand time when he looked at the clock and discovered that it was five minutes before deadline. What could he do, he hadn't even been to the scene of the murder?

He ordered himself another drink—an inspiration came. He called the editor and said: "The details are too horrible to report, see the AP wires." That is not how to get your news.

In reading your component medical society reports, I notice that most of them take the form of minutes and outlines. They add up to rather dull reading.

I feel that all of you men working in various parts of Maryland should know each other better. You can't know each other better by saying that Dr. John Jones has been appointed to this, and Dr. So-and-So to that—I think you need a little more human interest in your stories. But I also realize that the Journal representatives are very busy men and that this is just another chore to an already busy day. However, if you can put just a little more time on it, your editor will be much happier, I know, and your readers will get to know you as individual and interesting personalities.

Gathering the news depends very much on "W" words like "WHO"—"WHAT"—"WHEN"—"WHERE" and "WHY."

Now, in Dr. Somerville's report, he did a beautiful job, and not only that, he inserted some humor in it. The date of this particular one in case you want to check it, is December 1952. When I read it, I noticed the humor and almost fell out of bed—as I said I was reading very late—because it was the first humor I had found in any of these reports, and it was refreshing.

I found another lovely bit of writing, here from the Kent County Medical Society, which I thought was really very good. Dr. Robert Ensor, is he here? (No) Well he is going to shoot me for this. I read the whole article and thought "Oh, what a wonderful job." Here in the first paragraph he answers "What"—"When" and "Where." In the second paragraph he answers "Who," then going down further he expands and expands and expands and when I got through I said "There's a fellow that knows how to write. He should have been a writer

not a doctor." Then I noticed at the top it said that this report had been taken from the Kent County News—apparently verbatim. It was copied. So it's the Kenty County News reporter that deserves the bouquet.

It is often better when you write a story to write as though you are going to tell people a story. Be original; include human interest; answer all the questions; tell a good story. You have to have a nose for news. You have to know what *is* news.

I was talking to Dr. Wagner, and I said, "Well, what would be news to a doctor wouldn't always be news to a lay person." There you're kind of stymied. You do have to write primarily for your doctors and then for your lay person.

Now I also noticed that all these reports—well, say most of these reports—are about meetings and dedications. That is very fine but aren't there other news stories? There must be. Perhaps about a heroic doctor (this is a hackneyed example, I know), a doctor who got stuck in a snowstorm and who had to walk three miles so that he could deliver a baby. I'd be interested in reading something like that, other than "Dr. Jones is now the President of this, and Dr. Smith is the President of that."

Question: (From Audience) Our reports, most frequently, are factual records. How can they be made interesting?

Mrs. Tyson: Well, I like the way you're fighting back. Let's put it this way. Suppose a doctor apparently not too well known, has done some darn good research—perhaps it's not the greatest and he's not here in Baltimore at Johns Hopkins, but surely his story would be of interest to other doctors in the Counties. Maybe I'm wrong . . . before I came down here I asked Dr. Wagner, are you cramped for space because someone just mentioned twenty dollars a page. He said, "Not for the reports from the Counties." He said: "If they write the stories, we will put them in."

I said here that a human interest story can substitute for a news item. Dr. Somerville said "I never write anything unless I'm sure that I have a news item." But sometimes you have to look for one. I think it is good to have your Counties represented in each journal. I notice there are five Counties in one, and four in another, and some of the reports that you do have in here are very short and, well, they are just dull, forgive me. I'll leave with a knife in my back, I know.

I don't want to take up too much of your time, but let's now talk about *how* to write the news. Some of you have good stories, and if they were slightly rewritten they would be so much more interesting. Remember when you write a story, the most important part of it, as far as getting the interest of your readers, is your headline!

Someone will perhaps see a very long first paragraph, and start to read it; it seems dull and that is the end. Get a "meaty" first line and then remember for the sake of your editor, because he will sometimes have to cut if you do start writing more lengthily to put the important news first, then carry through with incidental information. When the editor has a cutting operation—which is certainly second nature to a doctor—he'll be able to do it easily without having to take a paragraph from the top; a paragraph from the middle; a paragraph from the end. Our Kent County Newspaper reporter started out with everything that was important first, then

expanded and added the unimportant but interesting background of the doctor who was involved. It was good reading. There was room for it, so Dr. Yeager used it in the Journal.

So remember when you are writing "a good lead line," your important news first, then your incidental information.

In straight reporting—and you're all up against that, you can't always inject your personality into it. So you just want to be clear and interesting, and now and then to inject a little bit of humor as Dr. Somerville did for your readers.

Are there any questions? I haven't covered everything. I know you are busy and I don't want to go on and on and on. Would you like to ask me anything? Put me on the spot because I know I've put you on the spot.

Question: Mrs. Tyson, what is your position here in magazines, are you just advising us now?

Mrs. Tyson: I'm the Assistant Publicity Manager of WBAL—WBAL-TV.

Question: (Same) Apparently the trouble with our news items has been that we have missed the one piece of humor that you found in 1952. We haven't known quite how to send these things in. Most of them are written very formally as you say, in an outline or in the form of minutes of a meeting. That, of course, is very dull and by the time you receive the Journal back, it is no longer news. Our response to the requests to meet the deadline have been very poor in my individual County. We have seen nothing of personal interest nor of personal account. We didn't know whether the contributions are to be formal or whether we are supposed to write informally or inject humor or not.

Mrs. Tyson: Well now you're up against something here. You have a formal Journal, there is no doubt about that.

Question: I'm talking about the County.

Mrs. Tyson: Yes, that is what I mean, but still you will find humor and human interest in the most formal magazines. I don't mean that you should be comedians, of course. Here is something I forgot and this is a good way to get your human interest in. Quote your men. Back here in this particular Journal "a renewed effort for the fight against socialized medicine was discussed." Apparently one doctor got up and gave a rip-roaring talk on his feeling concerning this. If you could have jotted down some of his sentences and quoted him, you would have gotten away from this sameness throughout your reports. I think that will help.

Question: Well, should this be a formal introduction of individuals who have amusing incidents and interesting social events within the individual Counties or formally informative of what goes on in the County?

Mrs. Tyson: Well now, I think it should be both. Your meetings are foremost and important and you have to put your minutes down, but now and then if I were editing this to make it more interesting, I'd ask each and every one of you now and then to write in a human interest story. You don't have a meeting all the time, do you? I mean there are times when you say "I have nothing to write" so you nose around and you talk to this doctor and talk to that doctor. Don't you think it would be more interesting if here, sandwiched among all these formal minutes and outlines you'd have a story, maybe just two paragraphs, but just a story?

Question: I do, but I found no other County who thought enough to write it in. That is why I asked you. That is the problem.

Dr. Yeager: Talbot County as a specific example, has sent in several human interest stories that have been published in the Journal, and Washington County has sent in one or two. I must say those are the only two that I can think of. They were published in more or less the type that was quoted here. This was Kent County. As I recall, that is the one you are quoting.

If you will review some of the correspondence when the Journal was first established, you will find that a plea was made to send in any newsworthy item, whether of personal interest or whether it concerns an individual doctor. I think most of the Counties are a little hesitant. They probably feel that the other Counties aren't interested in what they are doing. I think that is untrue. I think they are very much interested in the personalities of other Counties. We have never attempted to dictate the style of any reporting from a County whether it is formal, informal, humorous or anything else. May I interject the plea to please send us material that we can publish in reference to the personalities in your County Society.

Mrs. Tyson: If any of you do attempt to do these stories, remember that when you are interviewing a doctor who has perhaps done something unusual in research or something like that, to find out everything about him. Maybe you have known him since he was in knee pants, but somebody up in Washington County, perhaps, won't know somebody down in Arundel County and won't know his background, where he went to school or any unusual human interest story in his life. I think your County pages would be much more interesting if you developed your reports along this trend. Some of you look as though you don't agree?

Question: That is why we are here. Are these meant to be interesting or informative?

Mrs. Tyson: I'd say both. You are going to have your meetings and your minutes of your meetings, and you are going to have your outlines. They'll be here forever, I imagine, and they'll be strictly informative news but they're not going to do one little bit toward introducing the personality of the Medical Society of Anne Arundel County with that of the one up in Cumberland, etc. I feel you all should get to know each other better and the only way you can get to know each other better if it's not through personal contact is through your Journal.

Question: I'd like to ask Dr. Yeager one question. The trend of the discussion seems to be toward human interest stories. Is that what you'd like, Dr. Yeager?

Dr. Yeager: I'd very much like to have some stories of that type, to know what is happening to your local doctors. For instance, there will be an article published about Dr. Woodward, of Westminster, who is going to be given an award in Richmond. I see Dr. Baker here from Talbot County. There was a doctor given an award over in your County about a year ago and we published his picture. That represents very interesting reading to the general membership, in addition to the news items such as So-and-So was elected president.

I realize we have to put in factual information, but I had hoped we could publish material that will make the Journal look as though it represents a living, active organization.

Question: How much space do you give the County for it?

Dr. Yeager: I have never established any space limitation on the Counties, as I explained to Mrs. Tyson. I feel the Counties—and I include Baltimore City—the items of interest from each component society have number one priority. If material is deleted other types of articles are deleted, not County items.

Question: Would you like to have some scientific articles from the Counties?

Dr. Yeager: We have written for them. The response has been disappointing. We have had a few County scientific articles that have been published. Dr. Waters from Salisbury had one. Dr. Knox of Talbot County had one. There have been a few. Again I believe that the County members are too reticent. Baltimore and the two medical schools overwhelms them. This is primarily a society of general practitioners. The Journal, therefore, should not contain highly specialized articles or specialized techniques. With that viewpoint it seems to me the practitioners in the Counties could make many valuable suggestions and compose some very valuable articles. As long as I am editor of this Journal, I never anticipate publishing highly specialized articles. There are other journals to fulfill that need.

Question: Would you be able to suggest topics, say eight or ten? Will you constitute things of interest from the Counties that you specifically have in mind as news items? My difficulty is scarcity of items of news interest.

Dr. Yeager: I realize that is a difficulty, particularly in some of the Counties where we have a small membership. Mrs. Tyson, would you state what constitutes matters of interest to you?

Mrs. Tyson: Well, I can speak from my own personal experience about not having news, and all newspaper reporters too, will tell you that if you don't have news, make it. You can create news, and good writing will nourish it. Do you know there have been times at the station when I have felt, "There's nothing today." So then I think, "There must be something. There are at least two hundred people in this building right now and at least fifty of them will be on the air today, and I won't believe that one of them isn't going to do something worthwhile." I think if you really got nosy that you would find there is news in your County. There is news every day in this world.

Dr. Novak: What Mrs. Tyson has told us we can take to heart, but I think there are certain pros and cons to be considered. In the first place, my concept of the primary function of this journal is that it is going to constitute the future archives of our faculty; the dignified archives of the faculty, so that it has to be, I think, primarily factual and informative. In the second place, from the standpoint of the injection of human interest and perhaps the glamorizing of individuals or events, we have to remember that we belong to a profession which has some rather deeply rooted ideas of ethics which the laity may look upon as very silly, but which we have always cherished, and would not wish to depart from to any extent.

If, for example, to use the example that Mrs. Tyson gave us, you were to publish an article about Dr. So-and-So being called out in the middle of the night and dashing through snow-drifts to deliver a baby, it would not be very popular with a lot of his colleagues in his own or other counties who have done the same thing over and over again and haven't gotten publicity. This may be a rather extreme example, but we do have to bear these ethical ideas in mind in connection with the report which we are discussing.

In the third place, perhaps Mrs. Tyson hasn't taken sufficient cognizance of the fact that the readers of this journal are not going to be the laity. They are going to be other doctors who are pretty accustomed to reading the Council minutes. They have gotten big doses of such reading in the journal of the AMA. Look over the transactions of the AMA, and you'll find them pretty dull reading—deadly reading from a layman's standpoint—but they are informative. They don't have a spark of humor in them. I don't object to the humor. There are certain journals in which the personal . . . (Laughter) I believe I know the cause of this laughter. It is because you know that I happen to edit a journal in which the rather uninhibited comments are at times on the salty side, but remember that these also go to doctors, and not to the laity.

Mrs. Tyson is making a plea for good writing, which is to some extent acquirable, but which is more often an inborn gift. You can't make simple rules for a delightful style, but the general idea of making the content of our journal as light and as readable as possible, compatible with the ideals and the dignity of our profession, is an excellent one.

Dr. Yeager: Thank you Doctor Novak, Mrs. Tyson.

Mrs. Jewett: I think I have said enough.

Dr. Jewett: I can't help but agreeing with what Dr. Novak said. I think we can get the humor in the newspaper articles, in the magazines and in other journals, but I feel that the primary purpose of the State Medical Journal is as Dr. Novak has defined. We have to consider the cost of publication and even now we are trying to find more advertisers to defray the expenses. I think padding it with a lot of items which might be of local interest really would not serve any useful purpose as far as the inter-state society is concerned.

Dr. Yeager: Would you care to say anything, Dr. Baker?

Dr. Baker: I believe to get full cooperation from all the corresponding secretaries, it might be of some advantage if each County is given a small insert in alphabetical order, with or without a letter. It might be some stimulus to have the corresponding secretaries to fill a blank assigned to that particular local unit. That is the one thing I believe in regard to obtaining the cooperation of various Counties.

Dr. Yeager: The difficulty is, so many months we have absolutely nothing in regard to the Counties.

Dr. Baker: If that were assigned to them they would feel a responsibility of putting something of interest, of which I agree with the speakers here. There is always some items of interest that are many times left unsaid just from lack of initiative.

Dr. Yeager: We could attempt it. My only objection is that we "block out" space that could be filled.

Dr. Baker: It could just be a line, there wouldn't be any communication?

Dr. Yeager: Just say "no communication."

Question: If you take the four Counties on the upper Shore. That is—Talbot, Kent, Caroline and Queen Anne's. The majority of times there is absolutely nothing. In other words, in Talbot County we have an annual meeting at which we get a free meal from the President. The other four meetings that we have are in conjunction with the other three Counties. The so-called Upper Shore Society meets once a year in each County, so that once every three months we have a meeting. Aside from that unless we vote in a new member or something of that sort, we have an annual meeting in December.

Dr. Yeager: I know it is extremely difficult from many localities. Talbot County has one meeting in December to elect their officers. Somerset County didn't have a meeting for a year-and-a-half, so it is impossible to get a report from every County every month. They just don't have them. Dr. Novak and Dr. Jewett and Dr. Baker, you know, are members of the Editorial Board. Now I'd like to call on Dr. John Wagner, who is also a member of that Board, and the Chairman, to make a few comments.

Dr. Wagner: I'm just taking the opposing one, not to be in error but I think we ought to grasp the dual purpose of the Maryland State Medical Journal. It is a factual record of the formal activities of the Faculty, and of the Component Societies. And also it is—if you wish to translate its purpose into a common term—it is essentially a trade journal; it is an organizational journal and as such, it is an attempt to bring into unification the component parts of the organization. Therefore I feel that not necessarily from the point of view of humor but from the standpoint of originality you should inject your individual personality into your report from the County. That is a very important point to make. Not to attempt a cold, factual one, two, three, four report which, as one professor of Journalism in a mid-western university expressed: "What you doctors have to read is literally balderdash; if you had to sell that to the general public you would make no money but apparently you doctors have steeled yourselves to that arduous task of reading reams of uninteresting stuff."

Now, not that we believe that this should be a journal of humor, not at all, but if it could be lightened a little bit you will find, for instance, that an excellent article on the plans being made in the community in Talbot County for the enlargement of the Memorial Hospital, would be of very great interest in Washington County because maybe they wish to do the same thing out there. The leadership taken by the profession in Talbot County could very well be translated locally. Therefore, news which may be very commonplace to you, on the home front, will not be at all foreign to someone in another County, and the details are also important.

Next, this Professor of Journalism told me "there are three subjects people want to read about and you can check the first off for a doctor. The first is blood¹ sex, and themselves." (laughter) So let's forget the first two but I don't believe you will ever lose by collecting as many names as possible and putting them in the Maryland Medical Journal.

The Chairman of your local hospital fund should receive proper recognition. The local drive for the Red Cross and various other things which you may just pass by as being routine. Those people are going to be your constituents when

you attempt some Public service. If their names are recorded and their efforts in your behalf through the community, it would be proper to report that organized medicine in Maryland is going to benefit by it.

Don't forget to make note of the people who are presenting bills in the Legislature and various things of that type. I think if you dig a little bit and search your mind for originality, you will be able to bring up many an article. And then if you inject your own writing into it instead of just putting down one, two, three, four, not to the extent of making it redundant or for popular consumption but to enliven it up a little bit, I think you will get some results.

Dr. Yeager: I'm going to call on each one of you. If you want to ask questions of any member of the Board or Mrs. Tyson, I'm sure each will be glad to attempt an answer.

Before we start, I'd like to make these statements. We had hoped, in order to make the Journal a little more distinctive and a little more attractive, that the permanent sections of the Journal would be assigned an appropriate symbol. Each month you could go through it and know the sections you are dealing with.

For instance, the Blue Cross submitted a symbolic type of design, as well as the pharmacy section, the nursing section, etc. I wonder whether the Counties would want to develop some type of distinctive symbol. If so, we would certainly be very happy to receive them. Will you discuss it with the officer body and the general membership of your component Society? It may be you feel there is something distinctive about the County that to you indicates whether it is Kent County, Talbot County or some other part of the State. I believe that we could give the Journal a little more originality. With time, each month, we are going to add various types of symbols.

The Academy of General Practitioners—(I've talked to Mr. Wiscott about it), is attempting to evolve something for that section. I would like to have any suggestions that you care to make. Are the notices we send you each month insufficient? Would you like to have a different type of notice? As you know, we send a card reminder every month telling you when material should be submitted.

It is realized you have to submit material six to eight weeks before it is published. Before we compile it here, and by the time it goes to the publishers, there is a considerable lag. There is no way of circumventing such a lag. In submitting your articles you should write from the viewpoint that they are not going to appear in print for at least a month or two months. If you have any suggestions that you care to make from that viewpoint, I would appreciate them.

I have wondered whether we couldn't use more photographs in the Journal. It seems to me there are many possibilities in the Counties. Show the developments that are taking place in your County.

I know Garrett County has a new hospital. Calvert County has a new one, and Chestertown, also. If the contrasts in the developments that are taking place in the County can be shown it becomes more than a local interest. It becomes a statewide interest. I think there are any number of possibilities from that viewpoint that would make the County section infinitely more interesting.

All of us like to know what progress is taking place. I am

sure the general membership doesn't know there is a very excellent hospital in Chestertown. There is a very new and very excellent hospital in Oakland, and a new addition put on in Frederick, as well as Salisbury. They represent real progress. That is the type of information we would like to publish.

Dr. Fifer, I'll start with you at the end of the table. Would you care to make any comments or criticisms or suggestions as to what should be put into the Journal? We have avoided a discussion of scientific articles. If you want to criticize the type of scientific material we are publishing, certainly feel free to do it.

Dr. Fifer: The symbol would be for all the Counties together or individual County?

Dr. Yeager: Each County could have its symbol or if preferred it could be sectional.

Dr. Fifer: In reference to news, I find it has been particularly difficult to find material to write about. It has always been a question whether certain subjects could be of interest and just how they should be prepared. That has been my chief problem. I think you answered a number of those questions here today, and I would like to make one comment on the Journal from the scientific standpoint. In discussing it with some of the members in the County, one man made a suggestion I thought may be worth mentioning here. There's quite a raft of scientific literature, so much so that it is difficult for one to pick the good from the chaff, and this member suggested possibly a resume from certain meetings. Maybe there would be a symposium on heart disease or diabetes. A brief of that could be published in the Journal, boiled down so it would be practical and useable as a reference to the busy practitioner. It may be worthwhile in a Journal of this size and type. Possibly if twelve subjects could be selected and given to a group of representatives to abstract the literature, it might prove to be worthwhile and practical in a Journal of this type.

Dr. Yeager: I want to go over this again and make sure I understand you. One is, rather than to publish we'll say a diabetic symposium per se, to abstract it. The other is to select twelve subjects and each month publish what is new and what is current?

Dr. Fifer: Yes, that would give each representative one issue to review a particular subject. It would essentially be specialties boiled down primarily for the general practitioner.

Dr. Yeager: I think that is a good suggestion. As a matter of fact we are still trying to run this Journal on a shoestring. It becomes somewhat difficult to organize sections. Eventually we hope to establish them. We have not been assigned specific secretarial help. It is kind of a hodgepodge and it is rather difficult to do the things you have suggested. Is there anything else?

Dr. Acton: I think that for people in practice, a digest of treatment, given at regular intervals, is a very good thing. It is one of the things I like most about the New England Journal of Medicine, the "Medical Intelligence Section" that they have.

There is one thing that I have thought of that has not been mentioned and I ask it only half humorously. Will the editors see that we are protected against slander if we try to get too much "human interest." I ask that particularly, because of the

recent meeting of the City Medical Society. I tried to be circumspect, but I thought it should be mentioned.

Dr. Yeager: We have certain responsibilities that I hadn't thought of from the viewpoint of slander. I'm going to ask Dr. Novak to try to give an answer to that.

Dr. Novak: I'm not certain that I know just what Dr. Acton means?

Dr. Acton: Well to be specific at the last meeting one of the applicants for membership was rejected. I tried to mention it. Certainly it was newsworthy and should be mentioned, and yet one always wonders. I'm not an expert on the law of slander.

Dr. Novak: I can't answer Dr. Acton's questions as to specificity. Any offense that the person in question might take along legal lines would be against the City Medical Society itself and not against anybody who reports the transactions. But to get back to the question of having an abstract department or digest department, I don't see any great objection but I doubt its wisdom at this time. We would be duplicating what many other journals and medical digests are already doing. The little journals that are supported by advertisements, like the Current Medical Digest, and Modern Medicine, all do just that type of work. It seems to me we wouldn't have to be in any great hurry about starting an abstract of that sort, especially as it would be a rather elaborate and expensive undertaking.

Perhaps later on when we have a bigger journal with plenty of money to work with, it would be worthwhile considering such an addition, but I would not personally feel particularly enthusiastic about embarking on an undertaking of that sort now.

Dr. Cuvillier: The journal provides a record of general activities of the Faculty and from the standpoint of history I suppose this is a very important thing. The doctor here mentioned about having an abstracting service. Sure, there are plenty of abstracts you can read anywhere. Now the difficulty that I have is that there are some things I don't have time to read as for instance, last month's journal, the big story about tuberculosis. I haven't gotten started on that. I was told it is very good series of articles but I haven't read them. I don't know whether fifty per cent, or ten per cent, or ninety per cent of the membership, are in the same position. Now to change the subject a little bit.

My impression of this meeting was that you might say pep up the local correspondence. I wonder how this would work as an alternative to the existing setup. Have a column or maybe more than one column, of more or less different kinds of personal items rather than having twenty-three Counties and Baltimore City making twenty-four different sections. Group them together—say, here's marriages; here's deaths; here's births, etc., etc., and so-and-so spoke at our meeting, etc.

Now this proposition—I've been around a little bit and have heard some of this stuff we have heard today—how to write an article. Sure, you tell them right here in the very beginning there's a lot of people know that sort of thing. That isn't the kind of thing this is, this popular writing or publicity proposition. It's information that is hot today or this

minute and it's cold as an iceberg tomorrow. That is the problem.

We had a discussion at our Society meeting last Friday. I stated that I received a dead line notice of March 13th for the May Journal. Whether that is an exact date or not it's something on that order.

Dr. Yeager: I can't answer the problem of not reading the publication. Very few of us read the majority of the publications we receive. We probably read the summaries. If the article appeals to us we probably read it in toto. I'm equally sure there is a lot of medical literature which could be abolished and probably no great harm done. It is difficult for me to answer as to whether there is need of a State Journal.

The State Journal was developed because the Society was criticized from so many sources for not having one. That was particularly true of Baltimore City and particularly true of Prince George's and Montgomery County and many geographical border Counties. In general, it seems to be believed that it fulfills a worthwhile purpose. Beyond that I cannot go. I have never been able to answer the criticism "well, I don't have time to read these things." Probably there are many other publications that aren't being read. I know everyone is busy.

All of us should take a certain amount of time to read current articles whether "we have the time or not." You have to make yourself do it. I am sure that there are journals that are much more worthwhile from scientific interest. It was hoped that a Journal from the State Society could bridge the gap between a highly specialized scientific type of journal and factual, information in reference to Faculty activities. It was not the intent when the Journal was established to publish a purely scientific organ.

(Previous Speaker): Well, Dr. Yeager, I didn't mean to infer dropping the whole thing. What I meant to imply was that the thing could be reexamined in the light of what went before the journal was reinstated. It wasn't actually a new proposition; it was a reinstatement.

Dr. Yeager: As you know, before we had the journal we published a newsletter. Preceding that we had a little bulletin. About all the bulletin contained was a listing of the officers in the component counties and the titles of new books acquired by the library. Most people found that extremely dull reading. Perhaps we should revise our publication. I think time will have to tell us that. We haven't been publishing it long enough for thorough evaluation.

Dr. Somerville: I think the Journal is excellent from several standpoints. One is, it enables us to know what is going on in our own back yard. This is most important. In addition it assists us in current practice, research, etc.

The things I want to plug are some of the truths that have been mentioned. It is self evident that medical writing does not have to be dull. Dullness is not a prerequisite by any means. We are trying to disseminate information. We can only do that by making it a pleasure from one viewpoint or another.

Dr. Sprecher: I have already interjected my problem about finding news. I thought Dr. Wagner's remarks were particularly helpful to me along that line.

As far as using the Journal's scientific pages as abstracts,

I don't think there is any easy way of keeping up on medical literature. It is always going to be hard and will always require a good bit of work. With regard to scientific articles, one of the best was the first issue that came out with the symposium on Ulcer that was given here in a local meeting. I thought that was excellent. We could use some more of those.

Dr. Yeager: That seems to be generally true. Most readers seem to prefer a symposia. I must confess it represents the most stenographic and editorial work. It is first recorded and then transcribed, following which it entails editing. Have you ever edited anything that you have said? I can assure you, it will startle you.

From Audience: I remember Dr. Welsh, I happened to be chairman of the Committee on Public Instruction; the very first committee the State faculty ever had. They had Dr. Welsh give a good many talks. Many of you of the older men heard Dr. Welsh. He never wrote anything but always just talked it, and we had a stenographer take it down. Then I had to edit it and it was a very disillusioning process, as Dr. Yeager has just mentioned.

Dr. Yeager: Editing your own remarks is very apt to be disillusioning. You think you have given a satisfactory talk. However, when transcribed verbatim and seen in cold print it may be an abomination. Well, I remember the Ulcer symposia very distinctly. There wasn't anything in the spoken text that agreed with the written charts. The requisite correlation and revising presented a most formidable task.

Dr. Warren: I do feel the Journal serves a very important part of our medical tie with Baltimore. In addition such a medical center certainly should be represented by a Journal. Of course our County Societies, the component parts of the Medical and Chirurgical Faculty should also enter into it. We feel that the success of the "Medical Chi" is based on the interest demonstrated by the practitioner. The Journal could well represent the success of the "Medical Chi" as an organization. The interest we put into our articles will, I am quite sure, stimulate the interest of the individual members of the society to read the Journal, come to the meetings and generally make the "Medical Chi" a more successful organization.

The articles you suggest, of personal and general interest, are important. I'd like to ask if you'd be interested in some actual examination papers I have, of the Medical School in 1884. They are well preserved and I thought you would like or you might like to make a photostatic copy of them and perhaps print them. They are elementary, of course. However, I am sure we would be interested in knowing what they had to learn in those days.

Dr. Yeager: That would be excellent.

Dr. Warren: Fine, well I'll send them to you and let you make the photostatic copy.

Dr. Yeager: Dr. Welty, how do you feel about the idea of a symbolic heading of the Counties?

Dr. Welty: Should it be geographic?

Dr. Yeager: Wouldn't geographic be preferable?

Dr. Cuvillier: The symbol does not appeal to me. It would entail printing the symbol and leaving a blank space after the County that has not reported for that month. So far as the

news is concerned, my question has been answered by Dr. Novak and Dr. Jewett. I'm sure that many of the County representatives have hesitated to send in pieces of news that were interesting locally. Because they did not know with what attitude they would be received by the editors or by the other men in the State.

One item comes to mind that I, personally, had considered printing. In our county we now have a flair for red convertibles. Two years ago one physician bought a red "Austin Convertible" with a black top. Later, three others of us in the County bought red convertibles. There was no preplanning. It seemed to be the color of cars for doctors, red convertibles with black tops. That is amusing.

Of course if you name the man you will be endangering somebody for libel. I think it is not a thing of lasting interest to the archives, as Dr. Novak has suggested. News of that type has been omitted from the reports. The principle reason I think, that our County has failed to report more diligently is that we have a deadline of March 13th to make the May issue. We feel that there is a very little news we can put in with such a deadline.

Since I just represent the reporter, I'd like to take back either a good excuse for such an extended period from the deadline to the time of press, or a promise of some shortening of that time. We are fortunate in our own individual County in having available from two nearby universities and of course available from the Faculty, good speakers. We have a monthly meeting. It is a dinner meeting, very enjoyable and well attended. We have available very interesting speakers. They are carefully selected in order to attract a good attendance. I personally have noticed the interesting talks are those in which a competent man, usually a teacher comes to the meeting and reviews basic subjects that we had in Medical School, or as internes and residents. They amount to a good summary of what we had in Medical School with the additions in the past few years.

That is not interesting reading to anyone else in the State. It is interesting listening; it is not the type of thing that you would sit down when you have two hours off and read. When reading a symposium on Diabetes, for instance, it is seldom one can keep up interest through the whole article. To me the Journal is an organ by which we can learn about the men who are prominent in the individual Counties, their personalities and names. That is my idea of the purpose of the County contributions.

I am very much in favor of a column. We have heard from some of the men here that they do not approve of this personal issue in the Journal. I am very much in favor of a personal column. I don't think space should be allotted to it. However, in addition to whatever County news the reporters might have, they should hand in items of personal interest. Weddings, (we have some bachelors), young men out of universities and personal activities are of interest to those men throughout the State who know them. Deaths, of course, are not actually interesting but it is an item of news note that should be listed somewhere.

It is not a tremendous joke, but everyone seems to get a

kick out of the fact that some men have their fifth child or sixth child. That is an item of news.

I think Mrs. Tyson has misled the whole group in her very excellent speech on how to write an article for a professional magazine not for a lay consumption. I personally put no professional magazine on my stand out front. I try to keep current magazines there such as the Saturday Evening Post, Life, Liberty, News Week, and those things. But my professional journals I never reveal to my patients because they can get a much better symposium from the Reader's Digest, etc.

This Journal, as far as I am concerned, is purely for professional consumption. Any article should be written for their consumption. Lord knows we can pick up any of the forty-nine free journals and one paid journal every month and get a good symposium.

I think it is entirely up to the Board of Editors to select their professional articles either by contribution from the County or from their local staffs on which they have many excellent men. I don't think it is a duty of the Counties to contribute professional articles. There are very few men in any of the Counties that do research work.

Before I go home, I would like to have a clarification of whether or not you would like personal news.

Dr. Yeager: We have always thought it very desirable to have personal news.

Dr. Cuvillier: Well, we have thought it desirable to send it but as you have heard today, Dr. Novak and Dr. Jewett are opposed to it. It is not a matter of permanent record. We have hesitated to send in such things.

Dr. Jewett: I think the more any County report is personalized, the more names you mention the better, in a matter compatible with dignity.

Dr. Cuvillier: We don't plan nor expect to put in any items, of course, which would entail anything regarding libel or slander. They slip in.

Dr. Yeager: Dr. Novak raised an objection to the example cited of a specific doctor being stuck in the mud, or the snow. However, we would like to have personal items.

Dr. Cuvillier: That is what you would like to have?

Dr. Yeager: Yes. However, insofar as going back to your County with a promise that we can change our deadline, that is impossible. We have ten days from the time we receive your material to compile, assemble and re-type.

The material that goes to Waverly Press is submitted six weeks before publication. That may sound unreasonable. However, the publishing houses have schedules to meet. They have certain routines established just the same as you have routines established in a hospital. It goes to the composers, and is set up. It comes back to us in galley form, for corrections. It comes back a second time as page proof. A schedule is established for each year. The material for the May Journal, as an example, will be sent to the publishers the middle of March. I don't know of any way to short-cut unless we devise last minute insert pages in the center. It seems to me most of the news we receive just isn't of that much value from the

time viewpoint. I think you have to realize that old news in your County, is new news to the State Society.

Dr. Jewett: I think it is a rather short time by average stands. Most journals require a much longer preparatory submission of subjects.

Dr. Yeager: That is right. It isn't like a newspaper. I am sure Mrs. Tyson can tell you much more about newspaper deadlines. They are publishing current news. Dr. Novak might care to amplify. He has had infinitely more experience than I have in the problem. There is a lag which you cannot overcome.

From the time material leaves this office there is a six-week lag. I don't think it is unreasonable on our part to have a week to ten days for compilation.

Would anyone else care to comment?

Question: What is the date when you close an issue?

Dr. Yeager: It is approximately the middle of the month. I can't give you the exact publication date but it is about the middle of each month. I must say we don't always meet our deadline. Waverly Press falls down once in a while. Most often we are tardy, primarily because we don't have a specifically assigned secretarial staff, for this job.

Mrs. Tyson, would you care to tie this in a knot? Would you like a rebuttal?

Mrs. Tyson: Well, I first want to explain that story about the doctor and the snow was something I pulled out of the air. I realize how hackneyed such a story is, but it was the first thing that came to my mind in the way of human interest.

One other thing I would like to add. Dr. Novak said truly that writers are born and that you just cannot make a writer. However, there are certain rules to follow that can help anyone to write a good story. The lead line, and answering the all important "what," "where," "who," "why" questions at the beginning of the story, and writing clearly and interestingly.

I think that no matter how factual you are, no matter how dignified you are, you can still do a good writing job instead of this one, two, three, four, five, six, stuff—if you will excuse the word "stuff." That is all I have to say. I have been doing publicity and newspaper writing. Perhaps it is so different from this type of thing that I have gone off on a tangent with suggestions which you could never accept. However, they are in my line of work, and they are the rules I have to follow in order to assure myself that I'll get some type of good readership. That is all.

Dr. Yeager: Thank you very much, Mrs. Tyson. I want to thank all of you personally and on behalf of the Faculty Editorial Board for coming to this meeting. Some of you have traveled quite a distance. In the next few months I would appreciate comments from you as to whether you feel that it would be worthwhile to have such a meeting once a year. Apparently you believe it is more desirable to have a meeting at a time other than that of the annual meeting.

If you feel there is something to be accomplished by such a "get-together," we certainly would be happy to hear from you with an expression of your views. Again I want to thank all of you.

Component Medical Societies

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

The February meeting had an exciting program on Anesthesia. Out-of-town speakers presented two anesthetic types, new and different in Baltimore. Hypothermia and hypotension as anesthetic modalities, limited in scope and hazardous with pitfalls, were brilliantly detailed and fitted into the medical picture. Our thanks to Doctor Kenneth K. Keown and Doctor Hrant H. Stone of Philadelphia for their splendid papers.

Postgraduate Courses have sustained the early interest shown in them. Increasing attendance through the Dermatology Series has continued into the Hematology series. Seventy or more members have come to each seminar. Doctor H. M. Robinson, Jr., Chairman of the Postgraduate Courses Committee varied the time and places of meetings in a regular plan. Each course has a different meeting schedule so that many physician-practitioners and physician-teachers can fit them into variegated duties. With two more courses to go, the batting average is already .500.

Regular sections of the Executive Committee are held each month just before the monthly meeting. President Gundry initiated this staff briefing and discussion as a regular feature. As of this date, members and chairmen of committees for the year have not been announced. They probably will be known before this April issue goes to press. There will be changes, in line with the policy of revolving as many members as possible in the work of the society.

The Committee for Public Medical Education, Doctor Amos Koontz, Chairman, is expanding its work. Lectures on medical subjects are offered to interested lay groups. A list of appropriate subjects and titles was put together after consideration of similar programs in other states and cities. Original topics pertinent to Baltimore have been added. Letters telling of this activity were sent to more

than 700 organizations when the program was inaugurated the first of the year. More than thirty requests have come in during the first six weeks. Several lectures have been given and Doctor Koontz is gratified by the "fan mail" his team has received. For details consult the committee, or society headquarters.

BALTIMORE COUNTY MEDICAL ASSOCIATION

SAMUEL P. SCALIA, M.D.

Journal Representative

The Baltimore County Medical Association met at the Penn Hotel in Towson on February 17, 1954. A delicious crab cake luncheon was the order of the day.

The new Medical Directory will soon be ready. With the kind cooperation of the pharmacies in Baltimore County there will be ten thousand copies printed. This should give the directory, year round circulation.

Some questions were raised concerning medical society dues in Baltimore County. Dues in our organization are \$45.00 per annum, of this \$15.00 is retained by the County society and \$30.00 is advanced to the State. Increases in dues were voted last year both by the county and state societies. The high cost of operation necessitated such moves by the medical groups.

Dr. W. H. F. Warthen announced that a new bill of importance to the profession had been introduced to the House of Delegates in Annapolis. By means of this bill, anyone attending a state health clinic would be charged a fee of \$1.00. Dr. Warthen brought out the fact that the clinics are manned by volunteer workers, and such a fee might certainly influence them adversely to their work. Also, there would be added details of bookkeeping. It was decided to approach the Speaker of the House for a discussion on the bill.

With the help of our legal advisor, the application for membership in our county society has been revised. More professional background of potential

members is thus to be obtained. The new form was approved and passed by the Society. Dr. Ruth Baldwin of the Childrens' Seizure clinic at the University Hospital was the guest speaker. She presented a movie "Seizures." This movie was produced in cooperation with the Veterans Administration. It is quite a presentation, and concerns itself with a movie script-like story about epilepsy. The question and answer period following the movie brought the interesting meeting to a close.

WICOMICO COUNTY MEDICAL SOCIETY

W. STEDMAN SMITH, M.D.

Journal Representative

OBITUARY

RANDOLPH M. NOCK, M.D.

WHEREAS, Almighty God in His infinite wisdom has seen fit to remove from our midst our beloved associate and friend, Randolph M. Nock, who passed into the Great Beyond on December 15, 1953, and

WHEREAS, we wish to express our feeling of loss at his untimely death,

THEREFORE BE IT RESOLVED, that in the death of Dr. Nock the members of the Staff of the Peninsula General Hospital has lost one of its outstanding and most valuable members who, for more than a quarter of a century, has contributed greatly to the growth and success and reputation of the Institution, during which time he endeared himself to the officers of the Institution and his fellow members of the Staff, and

BE IT FURTHER RESOLVED, that in the death of Dr. Nock, we have all lost a valuable co-worker and devoted friend, the hospital a most valuable and conscientious physician and surgeon, and the City and County a most valuable and distinguished citizen, and

BE IT FURTHER RESOLVED, that these Resolutions be placed on the permanent records of the hospital and a copy sent to the widow of the deceased.

JAMES R. BISHOP, M.D.,

Chief of Staff, 1953

HENRY A. BRIELE, M.D.,

Chief of Staff, 1954

The above resolution was passed by the Peninsula General Hospital.

Dr. Randolph M. Nock was born in Hollywood, Va., on July 4, 1902. He moved to Stockton, Md., at six months and received his education there through high school. He attended College Park and University of Maryland Medical School and graduated in 1925. From 1925-1926 he interned Baltimore City Hospitals; from 1926-1927 Assistant Resident University Hospital; from 1927-1928 Assistant Resident Baltimore City Hospital, and from 1928-1929 Resident Baltimore City Hospital.

Dr. Nock started to practice in May 1929 at Salisbury, and originally was associated with Dr. J. McFadden Dick. He was a member of AMA, Wicomico County Medical Society, The American College of Surgeons, and Fellow of Academie Internationale of Medicine. He was active in the Masons and Rotary.

Dr. Nock was an active Staff member of the Peninsula General Hospital and had held positions as Chief of Staff and Chief of Surgery.

* * * * *

NEED FOR PHYSICIAN

The Springfield State Hospital, Sykesville, Maryland, is opening a newly-constructed and equipped Medical and Surgical Building of 149 beds about March 1, 1954.

It has need of a graduate of a Grade A medical school who has completed one year of a rotating internship in an accredited hospital, and has had two years of resident service in medicine. Two years medical experience in the Armed Forces may be substituted for one year residency, or five years practice of medicine and surgery may be substituted for the required residency. The salary scale is \$7100 to \$8520 and offers an opportunity for experience in psychiatry.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

DYSENTERY

LOUIS KRAUSE, M.D.*

This disease certainly existed in early mankind, but has been continuing more or less the same until relatively recently. The ancient references frequently referred to the condition either as an isolated instance, or in its epidemic form. Biblical references perhaps are referring to this condition when they speak of the people being afflicted with a "falling out of the bowels." Of course, we have no clear-cut indications as to etiology of the varieties mentioned in literature at that time. It is only in the last half century that the disease has been illuminated as to causation. And even more recent are the very specific drugs for bacillary and amebic varieties of dysentery. Progress in the recent years has been rather rapid.

The following list of books will present an overall picture from the early days up to the effective therapy of our era:

Areataeus, the Cappadocian. On dysentery. *In his* Extant works, ed. F. Adams, London, Sydenham Society, 1856.

"Prior to Lösch's discovery of *E. histolytica*, all forms of dysentery were differentiated only on clinical grounds."

Bancroft, Edward Nathaniel. An essay on the disease called yellow fever; with observations concerning febrile contagion, typhus fever, dysentery, and the plague, partly delivered as the Gulstonian lectures, before the College of Physicians, in the years 1806 and 1807. Republished, with notes, by John B. Davidge. Baltimore, Cushing and Jewett, 1820.

Bardsley, James Lomax. Hospital facts and observations. London, Burgess & Hill, 1830.

"First record of the use of emetine in the treatment of amebiasis."

* Chairman, Library Committee.

Bay, William. An inaugural dissertation on the operation of pestilential fluids upon the large intestines, termed by nosologists dysentery. New York, T. & J. Swords, 1797.

Chicago. Board of Health. Epidemic amebic dysentery: the Chicago outbreak of 1933. Washington, Gov't. print. off., 1936.

Cope, Zachary. Surgical aspects of dysentery including liver abscess. London, H. Frowde, 1920.

Craig, Charles Franklin. Amebiasis and amebic dysentery. Springfield, Thomas, 1934.

Craig, Charles Franklin. The etiology, diagnosis, and treatment of amebiasis. Baltimore, Williams & Wilkins, 1944.

Creager, Lewis, of Maryland. An inaugural essay on the dysentery, submitted to the trustees and medical professors of the University of Pennsylvania. Philadelphia, T. T. Stiles, 1806.

Fisher, James. An inaugural dissertation on that grade of the intestinal state of fever known by the name of dysentery. Philadelphia, Ormrod & Conrad, 1797.

Great Britain. National health insurance joint committee. Medical research committee. A study of 1,300 convalescent cases of dysentery from home hospitals: with special reference to the incidence and treatment of amoebic dysentery carriers. London, H. M. Stat. off., 1918.

Havens, Leon C. The bacteriology of typhoid, Salmonella, and dysentery infections and carrier states. New York, Commonwealth Fund, 1935.

Mann, James. A dissertation on dysentery, which obtained the Boylston prize medal for 1806. *In his* Medical sketches of the campaigns of 1812, 13, 14. Dedham, H. Mann and Co., 1816.

Manson-Bahr, Philip H. The dysenteric disorders; the diagnosis and treatment of dysentery, sprue, colitis and other diarrhoeas in general practice. Baltimore, Williams & Wilkins, 1939.

Rogers, Sir Leonard. Bowel diseases in the tropics; cholera, dysenteries, liver abscess and sprue. London, H. Frowde, 1922.

Winthrop-Stearns, Inc. Amebiasis. New York, Winthrop-Stearns, 1951.

Woodward, Joseph Janvier. Diarrhoea and dysentery. In U. S. War Dept. Medical and Surgical History of the Rebellion. Wash., Gov't. print. off., 1879.

"Garrison considered this the greatest single monograph on dysentery."

Zimmerman, Johann Georg. Von der Ruhr unter dem Volke im Jahr 1765. Zurich, Fuessli & Co., 1767.

"First important monograph on bacillary dysentery." Library also has English and French editions.

Descriptive notes taken from Garrison-Morton's "A Medical Bibliography." London, Grafton, 1943.

Many of the significant developments in our knowledge of dysentery have been reported for the first time in medical journals, most of which are in

the library's collection. The library staff will be glad to help locate these articles for any interested faculty members.

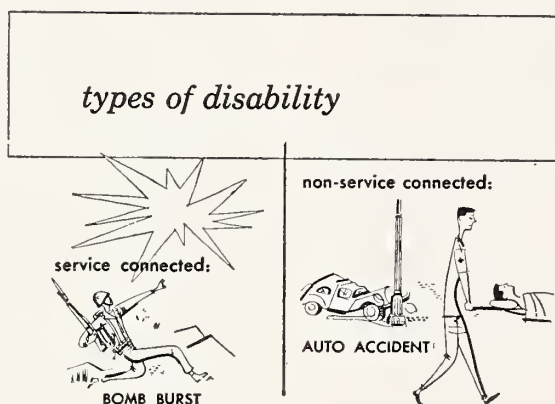
THE LIBRARY'S NEW LOOK

The open shelves ordered for the Reading Room should be in place by the time of the Annual Meeting. They will hold books published in the last ten or twelve years and make them readily accessible to users of the Library, in accordance with modern library practice.

The glass-doored bookcases can then be used to protect and display some of the rare old books now hidden in the stacks.

Come in and see the new arrangement, and make use of the Library's facilities!

In Viewing the VA Medical Program . . .



The medical profession fully endorses and supports the medical program of the Veterans Administration through which veterans receive medical care and hospitalization without cost for illnesses or injuries incurred as a result of military service (left). It is felt, however, that the federal government should not assume the responsibility for the medical care of veterans whose disabilities are incurred in civilian life and which have no relationship to their military service.

Health Departments

MARYLAND STATE DEPARTMENT OF HEALTH

Medical Care Program

Maryland's medical care program will be the subject of a series of 26 television broadcasts beginning March 11, Dr. Robert H. Riley, Director of the State Health Department and Dr. Mark V. Ziegler, Chief of the Bureau of Medical Services and Hospitals, State Health Department, have announced.

"Standing By," as the program will be entitled, will be produced by the Maryland State Department of Health and WBAL-TV in Baltimore. It will be broadcast on alternate Thursdays from 5 until 5:15 P.M.

Dr. Maurice C. Pincoffs, Professor of Medicine at the University of Maryland School of Medicine and a member of the State Board of Health, and Dr. William Ross Cameron, Washington County Health Officer, will be the guest speakers on the first program. The history of the medical care program will be the topic.

Dr. Herbert Notkin, Assistant Chief of the Bureau of Medical Services and Hospitals, State Health Department, and Mrs. Anne Holland, Director of Women's Activities for WBAL-TV's Public Affairs and Information Department, will be the moderators for the series.

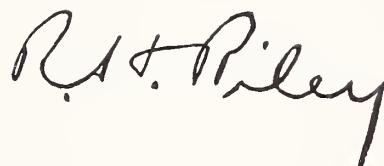
Various phases of the medical care program of the State and of the counties will be discussed with authorities as guest speakers.

"Standing By" is the second series of television programs currently being produced jointly by the State Health Department and WBAL-TV. The other program is "Let's Face the Problem," which deals with various aspects of alcoholism.

Joe B. Dellinger, Chief of the Section on Alcohol Studies, State Health Department, and Mrs. Holland are the moderators.

The alcoholism program is scheduled for alternate Thursdays at 5 to 5:15 P.M. Accordingly, the

medical care program will be on one Thursday and alcoholism the following Thursday.



Director

BALTIMORE CITY HEALTH DEPARTMENT

A Short Description of the Baltimore City Medical Care Program

All persons certified as being on Welfare Department rolls are eligible for services under the Baltimore City Medical Care Program, including (a) an initial general physical examination, (b) home and office care by a personal physician of the person's own choice, (c) freely available consultation, diagnostic and treatment services by specialists at hospitals, (d) laboratory and X-ray services, (e) necessary eyeglasses, (f) limited dental care and (g) drugs. The program is approved by the State Board of Health and is administered by the Baltimore City Health Department.

Each person upon admission to City Welfare Department rolls is notified that he is eligible to receive medical services under the Baltimore City Medical Care Program and is given instructions concerning it. He is advised to go to one of six large hospitals and give the name of the physician in his neighborhood from whom he wishes to receive home or office care when ill. Also at the hospital the person receives a general physical examination including all necessary laboratory and X-ray examinations. The results of the examination and advice regarding any need for treatment or special supervision are sent by the hospital to the personal physician. Thereafter the personal physician may apply to the hospital for any necessary examination or advice by a specialist,

and for any needed laboratory or X-ray examinations. When treatment by a specialist is required by an ambulatory patient, such treatment is provided by the hospital. Drugs are provided by the neighborhood pharmacist. Each person eligible for services under the Baltimore City Medical Care Program is

kept supplied with an up-to-date identification card showing his eligibility.

Huntington Williams, M.D.

Commissioner of Health

AUDIO-DIGEST FOUNDATION

AMEF Bulletin

The Audio-Digest Foundation was originally started as an adjunct to the public relations program of the California Medical Association and during the first year of its operation, it was so well received by individual members of the Association and local medical societies along the west coast that CMA officials realized it could well serve the nation's physicians if it were operated on a national basis. At the same time, the ADF would be useful as an added source of income for the American Medical Education Foundation. With this in mind, the Audio-Digest Foundation was incorporated under laws of the State of California and started promotion of its services on a national scale on January 1, of this year.

ADF services are available to individual physicians and state and county medical societies. They include: *a general practice digest* of abstracts of from 20 to 30 current scientific articles on one-hour tape recordings, which are available weekly at the subscription price of \$2.75 per week for one year; *specialty digests* in surgery, internal medicine and OB-GYN, which are published every two weeks at \$2.75 per issue for one year; and *lectures* on one-hour recordings with accompanying film strips. Non-illustrated recordings of the lecture series are available for \$3.75 per reel and illustrated for \$5.50 per reel.

Unquestionably the Audio-Digest Foundation's success at the national level will spell added dollars to the AMEF campaign for funds to assist the nation's medical schools. It has been estimated that the AMEF can net approximately \$1,000,000 annually from this source if the individual physicians in this country and state and local medical societies will give ADF their wholehearted support. ADF does not intend to replace the Foundation's annual campaign but it will augment the present income of the Foundation and at some future date, it could well become one of the major sources of regular income which will materially assist our medical schools to maintain high teaching standards.

All requests for additional information on Audio-Digest should be directed to Mr. J. L. Pettis, Executive Vice President, Audio-Digest Foundation, Inc., Suite 938, 417 South Hill Street, Los Angeles, California.

It should be pointed out that Audio-Digest does not seek contributions, rather, it sells a valuable service to physicians and their medical societies and it will keep them abreast of the fast-changing pace of modern medicine. This service is sold at a cost lower than the individual would pay for a one-hour blank tape at his local music store. At the same time, it will make a substantial contribution to the AMEF each year. The more subscribers of ADF, the greater the contribution from Audio-Digest to medical education.

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, February 26–March 25, 1954

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County.....	76	—	2	—	468	2	88	—	—	—	41	—	—	16	18	—	2	—	6
Anne Arundel.....	17	—	1	4	34	—	8	—	—	—	3	—	—	—	4	—	3	e-2	2
Howard.....	2	—	—	—	19	—	4	—	—	—	—	—	—	—	2	—	1	—	1
Harford.....	18	—	6	30	8	1	14	—	—	—	16	—	—	1	5	—	—	—	2
Carroll.....	1	—	1	—	52	—	2	—	—	—	9	—	—	—	—	—	1	—	3
Frederick.....	3	—	—	32	1	—	1	—	—	—	20	—	—	2	9	—	5	—	1
Washington.....	10	—	1	12	8	1	32	—	—	—	1	—	—	9	7	—	1	—	3
Allegany.....	4	—	—	4	1	—	2	—	—	—	—	—	1	—	—	—	1	—	2
Garrett.....	1	—	—	10	1	—	1	—	—	—	11	—	—	—	—	—	—	—	1
Montgomery.....	17	—	2	5	30	1	28	—	—	—	10	—	—	—	5	—	—	—	2
Prince George's.....	13	—	1	4	30	1	10	—	—	—	14	—	—	1	7	—	1	—	5
Calvert.....	1	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Charles.....	1	—	—	1	1	—	1	—	—	—	—	—	—	—	—	—	—	—	1
Saint Mary's.....	—	—	—	—	3	1	—	—	—	—	2	—	—	—	5	—	2	—	—
Cecil.....	—	—	—	4	18	—	2	—	—	—	1	—	—	—	3	1	2	—	2
Kent.....	17	—	1	2	11	—	8	—	—	—	4	—	—	3	—	—	—	—	—
Queen Anne's.....	3	—	1	—	3	—	1	—	—	—	—	—	—	—	1	—	—	—	—
Caroline.....	—	—	—	—	8	—	—	—	—	—	—	—	—	1	3	—	2	—	—
Talbot.....	—	—	—	—	1	—	—	—	—	—	—	—	—	3	2	—	—	—	—
Dorchester.....	6	—	—	—	3	—	—	—	—	—	—	—	—	—	—	1	5	—	1
Wicomico.....	3	—	—	2	41	—	3	—	—	—	—	—	—	—	2	—	9	—	2
Worcester.....	—	—	—	2	11	—	3	—	—	—	—	—	—	—	—	—	—	—	1
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Total Counties.....	193	0	16	113	752	7	208	0	0	0	132	0	1	36	74	2	35	—	35
Baltimore City.....	335	0	15	8	1520	1	205	0	0	0	97	0	0	37	110	14	419	—	30
State																			
Feb. 26–Mar. 25, 1954...	528	0	31	121	2272	8	413	0	0	0	229	0	1	73	184	16	454	—	65
Same period 1953.....	492	0	316	31	106	8	236	0	0	0	462	1	0	16	176	13	549	—	64
5-year median.....	561	3	165	—	825	7	206	2	—	0	167	2	3	34	223	41	502	—	81
Cumulative totals																			
State																			
Year 1954 to date.....	1695	4	84	343	4409	18	1185	2	0	0	578	2	1	242	495	54	1575	—	197
Same period 1953.....	1534	6	499	118	239	35	470	1	0	0	992	3	2	60	583	38	1793	—	331
5-year median.....	1427	14	261	—	2075	21	488	5	—	0	450	5	8	127	606	124	1575	—	212

e = infectious encephalitis.



Blue Cross - Blue Shield



BLUE SHIELD—A PROGRESS REPORT

R. H. DABNEY*

Blue Shield, now more than three years old, had another successful year in 1953, with substantial gains in enrollment, subscription income, and payments to physicians.

The figures set forth below on the number of subscribers enrolled and the number of cases handled indicate the steady growth which Blue Shield has enjoyed.

	<i>Subscribers Enrolled</i> (As of December 31st)	<i>Cases Paid</i>
1951.....	57,472	4,358
1952.....	84,738	8,669
1953.....	112,475	11,706

In terms of service to subscribers, the relationship between the number enrolled and the number of cases paid is significant. In 1951, for instance, only 76 out of every 1000 subscribers used Blue Shield benefits. Utilization increased as the Plan grew until, in 1953, 111 subscribers out of every 1000 enrolled received benefits. Of the more than 11,700 who used Blue Shield last year, 61 % received surgical benefits, 12 % used obstetrical care, and the remaining 27 % received medical benefits.

	<i>Subscription Income</i>	<i>Paid for Care</i>
1951.....	\$437,787	\$305,452
1952.....	\$737,324	\$654,825
1953.....	\$1,040,971	\$853,190

As noted from the above figures, subscription income passed the million-dollar mark last year, but, at the same time, total expenditures for medical care rose from approximately 70 % of income (in 1951) to 85 % (in 1953). This percentage of income returned to subscribers in the form of benefits was slightly higher than the average of 82 % reported by all Blue Shield Plans throughout the country.

Subscribers whose annual incomes didn't exceed \$3,000 for single persons and \$4,000 for married couples received service benefits under the contract without additional charge by the participating doctor. While our records do not indicate the exact

number of patients who were under or over these income limits, we do know that in 64 % of all cases handled, Blue Shield benefits were accepted as payment in full by treating physicians, and 36 % paid something in addition directly to the doctor.

The number of doctors who participate in the Plan has continued to increase. At the end of 1951, the first full year of operations, there were approximately 1400 doctors participating in the program. This number has increased steadily and there are now more than 1,730 doctors included. It is estimated that this total represents better than 90 % of the doctors in Maryland who ordinarily admit patients to hospitals.

These comments and figures concern our own Blue Shield Plan, but this progress would not be complete without mentioning the special program for Bethlehem Steel employees and their dependents. This program, different from our own, has been administered by Blue Shield, and, in itself, accounts for a substantial part of total business of Maryland Medical Service.

	<i>Subscribers Enrolled</i>	<i>Paid for Care</i>
1951.....	102,380	2,211
1952.....	107,171	9,964
1953.....	108,939	11,209

	<i>Subscription Income</i>	<i>Paid for Care</i>
1951.....	\$211,041	\$110,595
1952.....	\$643,658	\$499,157
1953.....	\$662,791	\$547,537

Here again, enrollment has been maintained at a high level and, since the effective date of the program, in October 1951, both payments and cases have increased steadily. In 1953, 84 % of the total subscription income was paid out in benefits for subscribers. This special program now provides only for surgical and obstetrical benefits and does not include benefits for medical care, anesthesia, or for consultations. Negotiations are now in progress which will very likely result in a considerable broadening of benefits under this program during the next year.

* Executive Director, Maryland Hospital Service, Inc., and Maryland Medical Service, Inc.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. CHARLES H. WILLIAMS, *Auxiliary Editor*

FIFTH ANNUAL MEETING PROGRAM

Monday—April 26, 1954—9-1 PM

Med. Chi. Ball

Alcazar

Tuesday—April 27, 1954—Sheraton-Belvedere Hotel, Baltimore, Md.

10:00 a.m. Registration

10:15 a.m. Business meeting, Mrs. John G. Ball, presiding

Election of officers

Special Reports—Organization, Legislation, Civil Defense. "Today's Health." Mental Health

10:45 a.m. Maryland Nurse Recruitment Film "Girl With the Lamp"—Courtesy of Baltimore City Auxiliary

11:15-12:00 noon Panel Discussions—Mrs. A. E. Goldstein, presiding

Nurse Recruitment—Mrs. James Kerr

Doctor's Day—Mrs. Gerald LeVan

12:15 p.m. Luncheon—Ballroom

Invocation—Sister Martha Hansen, Sc.D., Directing Sister, Lutheran Motherhouse, Ruxton

Address—"The Simplicity to Wonder"—Dr. John C. Krantz, Jr.

2:00 p.m. Hats and Furs Fashion Show—by Kitty Dierken, Star, Stage, TV and Radio

Music—by Jack Lederer

Postconvention meeting to be called by President

Wednesday—April 28, 1954

The ladies of the Auxiliary are cordially invited to join their husbands and attend the BUFFET SUPPER at 6:30 p.m., which will be followed by the evening meeting of the Medical and Chirurgical Faculty.

These will be held at the Faculty Building, 1211 Cathedral Street.

COMMITTEE FOR CONVENTION: Arrangements, Mrs. George E. Urban; Tickets and Reservations, Mrs. Otto C. Brantigan and Mrs. Louis C. Dobihal; Entertainment, Mrs. Thomas S. Bowyer; Registration, Mrs. George H. Brouillet; Hospitality, Mrs. Richard G. Coblentz; Publicity & Press, Mrs. Charles H. Williams; Flowers & Favors, Mrs. D. Delmas Caples and Mrs. Thomas E. Wheeler.

MRS. HOWARD F. ROOT

It is with a great sense of loss that we report the sudden passing of Mrs. Howard F. Root of Connecticut on March 7, 1954.

Mrs. Root was a Marylander, the sister of Dr. John T. King of Baltimore and the dear friend of our Maryland Auxiliary. She held office in the Woman's Auxiliary to the American Medical Association as a Director and it was always our pleasure to see her informally after the National meetings and discuss our mutual friends.

MEDICAL EDUCATION NEEDS THE SUPPORT OF "MRS." DOCTOR

NEWLAND E. DAY, M.D.

Seventy-nine medical schools graduating over six thousand doctors a year in this nation have turned to the Women's Auxiliaries of the Medical Societies for help in their fight to maintain academic freedom while continuing the climb toward even higher standards.

The crying need of these schools is financial. Problems have been increasing since before World War II, but have become critical since the post war era. What has happened revolves around finances, and involves personnel, materials, building maintenance, new construction and the ever increasing demand for more well-trained physicians as our population steadily increases and lives longer. Tuitions do not begin to pay the costs mentioned above. It costs a minimum of \$13,000 to graduate a Doctor and he pays hardly one-sixth of that cost in tuition. The chances are that even he doesn't realize that fact. However he must have wondered at times how his school was able to keep such public service-minded and selfless men, so highly trained as his instructors at such low pay levels. But even these men can reach a point where in self defense and out of necessity to maintain even minimum standards for their own wives and children they must seek employment elsewhere in a market highly competing for their talents.

It has been recognized, that increasing taxation has resulted in dwindling sources of endowment funds. Such a situation, uncorrected, could bring our medical schools to the only alternative of asking for government intervention in the form of financial aid. Medicine has long been aware that government aid, by its very character implies a degree of control which the professional groups have felt to be most undesirable and even dangerous to the freedom of our excellent systems of education.

A leader in the suggestion of alternative solutions was our (now) President Eisenhower, then President of Columbia University, around whom was created the idea of a "National Medical Education Foundation." This Foundation was developed to found a long range interest among the laity and industry in the problem. The "American Medical Education

Foundation" is its parallel to accomplish the same purpose with the doctors. Lay organizations and industry however, had to be assured that the Medical Profession itself was convinced of the worthwhile nature of the cause as evidenced by the physicians personal contributions to their own or other Medical Schools. The challenge was clear. The Need?—\$10,000,000 (ten million dollars), yearly to restore, and maintain in good order the present shaky financial structures on which our schools rest.

Into the fight have now been brought the spirited resources of the Women's Auxiliaries to our Medical Societies. These groups have in many instances caught the sense of urgency before their physician husbands, and with typical intuitiveness and resourcefulness cut red tape to get to the core of the problem. All they wanted to know was HOW CAN WE HELP? Then they came up with some of their own answers. Direct financial donations from these groups have resulted from such projects as splendidly produced Faculty Balls, card parties, fashion shows, and etc. Even with this splendid display of their belief in the project, more than that is needed. Talk to your "hubby" about HIS contribution to his medical school. Explain the advantage of making out a check payable to the American Medical Education Foundation, and earmarking on the check (or by letter with it) the school for which it is intended. This manner of making a contribution can enhance tremendously the evidence that industry is seeking. Show that we ARE concerned. Make it possible for our schools to obtain additional matching money, equivalent to the doctors contribution. THERE ARE NO STRINGS ATTACHED AND NO DEDUCTIONS FROM HIS CONTRIBUTION FOR ADMINISTRATIVE COSTS (all of which are borne by the American Medical Association and not by the Foundation contributions).

When needed in vital issues, you ladies have done it before. This is the chance for real progressive effort, not just a chance to criticize some other suggestions as to how the needs of private enterprise are to be met by government intervention. For further information inquire of your State Auxiliary representative to the American Medical Education Foundation, Mrs. J. Carlton Wich, or inquire at the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore 2, —attention A.M.E.F.

DOCTORS' DAY IN MARYLAND¹

March 30, 1953

W. ROSS CAMERON, M.D., M.P.H.²

INTRODUCTION

"Two powerful forces seem to be wrestling with one another. One, a force of blood and of death, is constantly devising newer means of destruction. The other, a force of work, of peace and of health, is continuously developing better methods of delivering mankind from the scourges which beset him."

These words are as true today as when they first were spoken by Louis Pasteur over 75 years ago. In a "cold" war that is not so cold, one force is seeking to conquer the free world by violence, and is compelling all nations constantly to be ready for the battlefield. The other force is continuously working to relieve suffering by delivering humanity from its diseases. That force is the medical profession, a group which the citizens of Maryland pause to honor on this day, Monday, March 30, 1953.

The voice to which you are listening is that of a physician. He is not, however, engaged in the private practice of medicine, but for many years—day by day, and week by week,—he has been in a position to observe the doctors at work—not only in this county and in this state, but in other states and in other countries.

During the past two years the speaker has served with the United States Armed Forces in China—or what remains of that unhappy nation on the island of Formosa. There, it has been a custom of many years standing for each community to honor all its doctors on one day of each year. On two occasions your speaker was a guest of honor during the celebration of *Doctor's Day* in China. Not only all physicians but the members of their families were feted and otherwise entertained by the communities in which they serve. There were many impressive demonstrations of the affection with which Chinese physicians are held by the entire population.

REASONS FOR DOCTORS DAY

So far as can be determined, this is the second Doctors' Day in Maryland. It affords the speaker

¹ Radio Broadcast: Station WARK, Hagerstown, Md. 4:30 P.M. March 30, 1953. Permission for reprinting granted.

² Deputy State and County Health Officer.

great pleasure to join his voice with those who would pay their respects to the private practitioners of medicine on this occasion. He also would like to think that he is honoring physicians who, working in hospitals and in research laboratories, also have done much to increase our knowledge of the art and science of medicine.

"Oh," some may say, "it may be quite in order for the Chinese to have their Doctors Day, but why should this custom be adopted in the United States and particularly in Maryland? Have not our physicians received their reward in the form of financial payments for services rendered?"

When one considers this subject even for a short time, there comes to light a number of reasons why it is appropriate that a special day be set aside for this purpose. Time will permit us to discuss only two.

1. The *first* reason is that over the years the doctors in this State have made exceedingly valuable contributions to the very striking progress that has been made in medicine.

At the turn of the century many of the current methods of treating the sick and preventing disease were undreamed of. There was no X-ray. Radium had not been used for medical purposes. Vitamins were unknown. Immunization against many communicable diseases had not been attempted. No one had drawn blood from a vein to make chemical or bacteriological studies. There were no such words as allergy, basal metabolism, and many others which are in common use today. A surgical operation was an extremely hazardous adventure. Diagnostic procedures too numerous to mention had not been developed.

Summer invariably brought its heavy toll in deaths of infants. Typhoid came early in the fall, followed by diphtheria and scarlet fever in epidemics with a high death rate. Tetanus was a common and almost always lethal complication of a serious wound. Cerebrospinal meningitis raged in epidemics in which as many as 80% of its victims died.

That was the state of affairs in the medical field in Washington County at the turn of the century. As late as 1930, however, when the speaker first came to Hagerstown, conditions were not much better. It is quite clear, therefore, that in the last 50, and especially in the last 25 years, advances in

medicine have been almost unbelievable. In effecting this phenomenal progress, each private physician in Washington County has played his part.

During the period under review, major advances include the following:

(a) In surgery, the technical progress has been fabulous: rubber gloves, new suture materials, improved asepsis and anesthesia, better methods of treating shock, and new territories have been opened up by pioneers in chest surgery and brain surgery.

(b) Summer diarrheas and typhoid fever have all but vanished as a result of improvements in the sanitation of handling water, sewerage, food and milk.

(c) Diphtheria, and other diseases such as tetanus, which are prevented by immunization of various kinds, now are almost completely under control.

(d) In one form or another the new sulfonamides, penicillin, and many of the so-called "wonder drugs" have a specific and curative effect on a high proportion of the common bacterial diseases: pneumonia, gonorrhea and syphilis, meningitis, and erysipelas—to mention but a few.

(e) Early diagnosis and treatment in sanatoria, artificial collapse of the diseased lung and other forms of surgery, as well as some of the most recently discovered drugs, make the future of the tuberculosis patient very hopeful indeed, and the possibilities of complete control of this disease have been greatly enhanced.

WHAT ARE THE RESULTS OF THIS AMAZING PROGRESS?

(a) People are living healthier and, we trust, happier lives—lives which have been lengthened 5, 10, 15, or even 20 years.

(b) The number of persons living past the 40th year is greater than ever before. Unfortunately, however, this has resulted in an increase in the prevalence of diseases like cancer, heart disease, diabetes, and mental disorders which occur more often in people in the middle and older age groups.

(c) Advances also have been made in controlling diseases in the aging population. Doctors cannot provide new hearts, but some can be repaired, and old ones are being treated more successfully. In the battle against cancer, though the cause is obscure, much has been accomplished through an active campaign of public education, by more prompt

diagnosis, as well as by use of radium, x-ray, and surgery. The lives of many cancer patients have been saved and much suffering averted.

2. The *second* reason for honoring doctors on this day is that they occupy a unique place in the minds and hearts of the people.

For many of us the family doctor is one of our warmest memories and, fortunately, a relatively large number of general practitioners still practice in Washington County. Many of them lead unselfish and truly heroic lives, working not a 40 or 60 hour week, but more nearly continuously, without holidays and sometimes without sufficient sleep. In spite of the demands upon them, a high proportion manage to keep abreast of the times. It is a killing job. Unfortunately, however, the extraordinary advances in medicine rapidly are making the science of healing too vast for one man to carry in his head. The services of the family doctor now are being augmented to quite a significant extent by the specialist.

As it was with the saint who saw us through whooping cough and measles, it also is the primary purpose of the doctors living today to restore people to health and happiness—but this objective is reached in a different way, often with the aid of a specialist.

The modern physician is neither a saint, nor a soldier, nor a social worker. He is an intensely devoted and scientifically inspired expert in his profession. It is his consuming interest and purpose to see to it that the patients whom he treats are well treated. His chief consolation is to feel that he may help those living today, as well as those who come after him, to do better than himself—so that they may fix their eyes on those great horizons of which he has only caught a glimpse.

CONCLUSION

By way of summarizing what has been said, you are reminded that today the accumulated medical knowledge of the ages is at our command. Today, thanks to the guidance of the Great Physician, mankind is to a greater extent than ever before the master of his medical destiny rather than the victim of the grim hand of fate. Today it is not too much to anticipate that another 50 years—nay, less—may deliver up the answers to many of the questions which currently baffle physicians.

On Doctors' Day, the bands are not playing, the streets are not lined with cheering spectators, but medicine is indeed on the march. The doctors of Maryland are in the vanguard.

BIBLIOGRAPHY

1. *The Life of Pasteur*, R. VALLERY, Rodot, Garden City Publishing Co., Inc. pp. 339, 444.
2. *The Doctors Job*, CARL BINGER, W. W. Norton and Co., Inc. pp. 156, 167.

FROM PRESIDENT EISENHOWER'S SPECIAL MESSAGE TO CONGRESS ON HEALTH

The AMA Washington Letter—No. 55

In a special message to Congress on the nation's health problems, President Eisenhower proposes the following:

Medical Care—Reinsurance. "Better health insurance protection for more people can be provided . . . The government can and should work with them (private and non-profit organizations) to study and devise better insurance protection to meet the public need. . . I recommend the establishment of a *limited federal reinsurance service* to encourage broader health protection to more families. This service would reinsure the special additional risks involved in such broader protection. It can be launched with a capital fund of \$25 million provided by the government, to be retired from re-insurance fees."

Rehabilitation. "There are 2,000,000 disabled persons who could be rehabilitated and thus returned to productive work. Only 60,000 now are being returned each year. Our goal should be 70,000 in 1955 . . . for 1956, 100,000 . . . In 1956 the states should begin to contribute to the cost of rehabilitating these additional persons . . . By 1959, with . . . states . . . sharing with the federal government, we should reach the goal of 200,000 . . . We must extend greater assistance to the states (for) . . . specialized training of personnel . . . research, clinical facilities for rehabilitative services . . . the development of community centers and special workshops." Details of cost to be set forth in budget message.

Construction of Medical Facilities. "New hospital construction continues to lag behind the need . . . (but) . . . hospital construction meets only part of the urgent need for facilities . . . I . . . propose added assistance or assistance in the construction of (a) non-profit hospitals for care of chronically ill, (b) non-profit medically supervised nursing and convalescent homes, (c) non-profit rehabilitation facilities for the disabled, (d) non-profit diagnostic or treatment centers for ambulatory patients . . . I (also) recommend . . . special funds be made available to the states to help pay for surveys of their needs." (Legislation already introduced in both houses provides for grants of \$20 million for diagnostic or treatment centers, a like amount for chronic disease centers, and \$10 million each for rehabilitation facilities and nursing homes. These sums would be in addition to the appropriation under the regular Hill-Burton Act, which this year is \$65 million.)

Other Federal Programs. A "new approach" in grant-in-aid would apply a "simplified formula . . . permitting the states to use greater initiative in state programs and take more responsibility . . . States (would be) aided in inverse proportion to their financial capacity . . . A proportion of the federal assistance to be set aside for support of unique projects of regional or national significance which give promise of new and better ways of serving the human needs of our citizens."



The State of Maryland

Executive Department

GOVERNOR'S PROCLAMATION
"DOCTORS' DAY"
March 30th, 1954

The importance and usefulness to humanity of medicine and chirurgery have increased through the years with each advance of the practitioners in the broad sphere of their knowledge.

We are living in one of the truly great ages of research and study. Long strides are being taken in the alleviation and curing of ancient ailments.

Never were the men and women of these and related sciences more devoted to the understanding and the practicing of their professions.

We already see the results in new attacks against old diseases, and the horizon is bright with new hopes--new faith in the skills and learning which God gives to those who choose the life of devotion to the arts of healing.

In Maryland--particularly in the metropolis of Baltimore--the world has one of its greatest centers for the developing and disseminating of advanced knowledge in medicine and surgery.

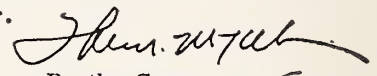
It is a distinction of which we are particularly proud.

With the cooperation of our fine surgeons and physicians, too, our State has developed a pioneer plan of rendering needed aid to our unfortunate citizens who are, through no fault of their own, indigent or unable to support their own needs for medical and surgical treatment.

It is our State's sound answer to those who would inflict upon our people as a whole the unwanted and unwieldy socialization of medicine which has crept into the society of less progressive nations.

In recognition of our State's leadership in research into human ills, its treatment of human diseases, and its advanced care of its citizens, and in gratitude to the great men and women of past and present who practice the professions of medicine and chirurgery among us, I, Theodore R. McKeldin, Governor, do hereby proclaim March 30, 1954, to be "DOCTORS' DAY" in Maryland.

GIVEN Under My Hand and the Great
Seal of the State of Maryland, at the
City of Annapolis, this 8th Day of
February, in the Year of Our Lord,
One Thousand Nine Hundred and
Fifty-Four.


By the Governor
John R. Beane
Secretary of State



Maryland Academy of General Practice

President—LAURISTON L. KEOWN, M.D., Baltimore

President-Elect—MERRILL M. CROSS, M.D., Silver Spring

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ROBERT VAN L. CAMPBELL, M.D., Hagerstown

Executive Secretary—MR. WILLIAM J. WISCOTT, Baltimore

Postgraduate Medical Seminar—May 13, 1954

The regular spring meeting of the Maryland Academy of General Practice will be held this year in Hagerstown, Maryland, at the Alexander Hotel, Thursday, May 13, 1954.

The subjects to be discussed include:

Intracardiac Surgery

Hypertension in Unilateral Kidney Disease

Diagnosis and Treatment of Poliomyelitis

Skin Manifestations of Certain Internal Diseases

Management of Prolonged Labor in Childbirth
Present Day Concepts on Burn Therapy
Advances in Neurology

The morning session which will begin at 10 o'clock, will be followed by a luncheon at the Alexander Hotel, with Lederle Laboratories as host. Panel discussions will follow both the morning and afternoon program. The meeting will end with cocktails and hors d'oeuvres following the afternoon session between 5 and 6 p.m.

All members of the medical profession in Maryland and their wives are invited to attend. There will be no registration fee.

CONGRESS RECEIVES RESULTS OF BOLTON POLL ON NURSE SHORTAGE

The AMA Washington Letter, No. 60

The nurse shortage in the U. S. is acute and remedial action is urgently needed, Rep. Frances Bolton (R., Ohio) has informed Congress. Her findings were reported to the House as a result of a poll sent to 10,000 nurses, physicians, hospital administrators, state and federal officials and other interested laymen. Mrs. Bolton reported she had received returns from 38.5% of those sent questionnaires. Mrs. Bolton introduced a bill early in the last session for a federal program of grants for graduate nurse training and practical nurse training. The American Medical Association, in testimony to the House Commerce Committee, reiterated support of one-time construction or renovation grants to nursing schools on a matching basis and grants to states for advanced nursing scholarships.

Mrs. Bolton listed these findings, among others, in her report to the House: (1) Nurse shortage is most critical in general and private duty nursing, followed by teaching, supervision and administration categories, (2) low pay and long and irregular hours are major factors in the shortage, (3) more funds to nursing schools should remedy the shortage, and (4) a program of state-administered, federal-state matching funds is the preferred approach to the problem.

Book Reviews*

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them.

Stedman's Medical Dictionary. Edited by Norman Burke Taylor, V.D., M.D., F.R.S.C., F.R.C.S. (Edin.) F.R.C.P. (Can.) M.R.C.S. (Lon.) in collaboration with Lieut. Col. Allen Ellsworth Taylor, D.S.O., M.A. Eighteenth Revised Edition. 1561 pp. 16.4 x 24.7 cm. The Williams & Wilkins Company, Baltimore, Maryland, 1953. Price \$11.50.

This new edition has been brought up-to-date with the addition of several thousand words. There are nearly 600 illustrations, including many original drawings, which are excellent. Thumb indexing is extremely convenient.

Although the print is small, it is very easy to read. Word derivations are clear and should be easily understood by students in various professions, who would have the most occasions to use this in their studies.

Tables, including Areas, Arteries, Veins, Bones, Ducts, Ligaments, Muscles, etc., are excellent.

The Appendix includes Weights and Measures, Symbols, Stethoscopic Abbreviations, Temperature Scales, Barometer Scales, Chemical Elements, Pathogenic Microparasites, New Nomenclature, and Standard Weights.

The information and scope of this reference is compre-

* The reviews here published have been prepared by competent authorities and do not represent the opinions of any official bodies unless specifically stated.

hensive and invaluable. It represents a reference of broad information, valuable to both the individual and to libraries.

G. H. Y.

The Anatomy and Surgery of Hernia. Leo M. Zimmerman, M.D., Professor of Surgery and Co-Chairman of the Department of Surgery, Chicago Medical School. Barry J. Anson, Ph.D. (Med. Sc.) Professor of Anatomy, Northwestern University Medical School. The William & Wilkins Company, Baltimore, Maryland, 1953. Illustrated, 374 pages. Price \$10.

This modern volume on an old subject should prove a welcome addition to the library of any surgeon dealing with the problem. The subject material is presented in a well organized and digested way.

Chapter II on "Hernia in General" is evidence of a great amount of material, informatively summarized and presented. A chapter is devoted in a didactic yet condensed manner to each type of hernia, complete from definition, incidence, symptoms, etc. to acceptable operative, corrective procedures.

A chapter "Hernia Through the Ages" reads as easily and as interestingly as a novel. Throughout the volume, excellent illustrations and photographs accompany the text, well exemplified in the chapter "Anatomy of the Abdominal Wall." This practical monograph on Hernia should serve as a good, up to date review for anyone engaged in abdominal surgery.

H. C. H.

FEDERAL EMPLOYEE HEALTH INSURANCE PROPOSED

The AMA Washington Letter, No. 60

President Eisenhower has announced that later in the session Congress will be asked to set up a program of contributory medical care and hospitalization insurance open to all federal employees, and supported in part by an annual contribution of about \$50 million from the U. S. government. Payroll deductions, presently forbidden under federal law, would be authorized. The plan is reported to include these other points: (1) The government and the employee to share equally premium costs up to \$25 per year per employee, with the latter paying all costs above that figure. The employee would have his choice of hospitalization, surgical care and medical care, or all three, for himself and his family, but the U. S. contribution would not exceed \$12.50. (2) Private insurance groups—Blue Cross and Blue Shield, White Cross, and cooperative group health plans—would handle the insurance. There would be no set formula, but details would vary among departments and geographic areas. The administration also is proposing that Congress authorize federal contributions toward life insurance policies for U. S. employees.

COMING MEETINGS

ANESTHESIOLOGY SECTION

1211 Cathedral Street, Baltimore

CHARLES F. HOBELMANN, M.D., *Chairman*

LIONEL GLASSMAN, M.D., *Secretary*

FRANK J. BRADY, M.D., *Program Chairman*

Tuesday, May 4, 1954, 8:30 p.m.

Business meeting.

THE SIXTH ANNUAL MEDICAL AND SURGICAL SYMPOSIUM

Sponsored by the Medical Association of the Lutheran Hospital of Maryland

Date: Saturday, May 8, 1954.

Place: Nurses Home, Lutheran Hospital, Ashburton Street and Rayner Avenue.

Morning Session: 10:45 a.m. to 12 noon

"Thin Bones, Old People, and Hormone Therapy," Edward C. Reifenstein, Jr., M.D.

Luncheon: 12 noon to 1:30 p.m.

Afternoon Session: 1:30 p.m. to 3:30 p.m.

Panel Discussion: Hypertension

Moderator

Louis Krause, M.D., Chief of Medicine, Lutheran Hospital, and Professor, Clinical Medicine, University of Maryland School of Medicine.

Participants

William A. Jeffers, M.D., Chief of the Hypertension Section, University of Pennsylvania School of Medicine, and Associate Professor of Medicine.

Paul Kimmelstiel, M.D., Pathologist and Director of Clinical Laboratories, Charlotte Memorial Hospital, Charlotte, North Carolina.

Thomas J. O'Neill, M.D., Associate Professor of Thoracic Surgery, Graduate School, University of Pennsylvania School of Medicine, and Associate in Thoracic Surgery, Hahnemann Hospital, Philadelphia, Pennsylvania.

Question Period

MARYLAND PSYCHIATRIC SOCIETY

1211 Cathedral Street, Baltimore

LEONARD J. GALLANT, M.D., *Secretary*

Thursday, May 13, 1954, 8:30 p.m.

Clinical and Physiologic Psychosomatic Studies of Patients with Hypertension. Captain MORTON F. REISER, United States Army, Walter Reed Hospital.

Discussants: MAURICE H. GREENHILL, M.D., Associate Professor of Psychiatry, University of Maryland.

MARYLAND RADIOLOGICAL SOCIETY**Second Annual Meeting**

JOINT MEETING WITH THE RADIOLOGICAL SECTION OF THE BALTIMORE
CITY MEDICAL SOCIETY

Saturday, May 15, 1954

Hotel Alexander, Hagerstown, Maryland

If you wish additional information regarding this meeting, contact Dr. Richard B. Hanchett, telephone VERNON 7-6500.

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

1211 Cathedral Street, Baltimore

Sponsored by the Maryland Division of the American Cancer Society and the Medical and
Chirurgical Faculty.

RICHARD W. TELINDE, M.D., *Chairman*

BEVERLEY C. COMPTON, M.D., *Secretary*

Thursday, May 20, 1954, 5:00 to 6:00 p.m.

MATERNAL MORTALITY COMMITTEE

1211 Cathedral Street, Baltimore

Thursday, May 27, 1954, 4:00 to 5:00 p.m.

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the
Baltimore City Health Department.

**PAN AMERICAN CONGRESS OF OPHTHALMOLOGY MEETS IN
SÃO PAULO IN JUNE**

June 17-June 21, 1954

The Pan American Association of Ophthalmology will hold its Third Interim Congress June 17 to 21 in São Paulo, Brazil, under the presidency of Dr. Moacyr E. Alvare of São Paulo. The meeting is of special interest because it is one of many official events in the celebration of the quadricentennial of the host city this year.

A.M.A. NEWS RELEASE—WASHINGTON OFFICE

THE MONTH IN WASHINGTON

Washington, D.C.—Just about a year ago the Hill-Burton hospital construction program was under heavy attack in the House Appropriations Committee. But the damage was not permanent. The program has made a complete recovery. More than that, Congress shows every intention of doubling the appropriation for the program, but earmarking the additional money for grants to diagnostic and treatment centers, rehabilitation facilities, hospitals for the chronically ill, and nursing homes. At this stage the legislation to stimulate health facility construction is believed to be closer to enactment than any other major health project of the Eisenhower administration. Although the main objectives have not been altered, some significant changes were made in the bill by the House Interstate and Foreign Commerce Committee in two weeks of intensive work at closed-door sessions. Then, in mid-March, the Senate committee took up the bill and considered additional amendments.

Most changes are designed to tighten up eligibility for grants. For example, money could go to only two types of diagnostic or treatment centers, those operated by and for a governmental unit or by a group that also operates a nonprofit hospital. Nor would centers or nursing homes be eligible unless under medical supervision or operated by an association that also operates a hospital.

Another change written into the bill would rule out a project if it were not to be open for full and unrestricted use by the general public. Thus labor union, fraternal, and prepayment health plans could not benefit if they offered their own subscribers any advantage in service at the center or hospital.

On the financial side, several amendments have been tentatively adopted. One would allow states to use the original Hill-Burton formula for apportioning money among projects, or to accept a flat 50% federal contribution. (As in the original Hill-Burton act, the poorer states would be allocated more per capita.) States would be allowed to pool their allocations for construction of interstate facilities, and the United States would be authorized to recover its proportionate share of a project if at any time the project were converted to profit use or were transferred to interests which for any other reason would not be eligible.

Of major interest to the medical profession, although not far along on its legislative course, is the administration's proposal for subsidizing prepaid health plans for federal civilian employees. The U.S. would pay a maximum of \$26 per year, to be matched by the employee, for the purchase of any type of prepaid insurance. Any cost above \$52 per year would have to be borne entirely by the employee.

As a part of the program, the administration is proposing that payroll deductions be authorized, a concession the insurance and prepayment insurance organizations have been urging for years. Currently federal executives differ on whether payroll deductions would be "legal," but none is willing to risk authorizing deductions in the absence of specific approval from Congress.

Still following a slow and controversial course is the administration's proposal for reinsurance of health plans. Early in the session—with the ardent support of Chairman Charles S. Wolverton of the key House committee—this legislation appeared pointed toward enactment. However, the Department of Health, Education, and Welfare was not satisfied with Mr. Wolverton's bill and decided to draft one of its own. The drafting consumed many weeks—time that may prove fatal with a Congress hoping to adjourn early for the fall elections.

The Defense Department, made uncomfortable by a few suspected subversive physicians and dentists it doesn't quite know what to do with, is asking for an amendment to the Doctor Draft act. The department's problem is this: The most recent Court of Appeals decision holds

that physicians or dentists drafted or called up from the reserves must, under the Doctor Draft act, either be commissioned or discharged. So, technically, a man who refuses to fill out his loyalty questionnaire would be rewarded by a release. To correct the situation, the Department is asking that the law be changed to allow it to withhold a commission from a loyalty suspect, yet keep him on duty for the specified time in noncommissioned status and assigned to professional duties.

The American Medical Association is continuing its support of Senator Bricker and others who are convinced they still can enact a resolution calling for an amendment to restrict international agreements. The Association's position is that unless a safeguard is written into the Constitution, future international agreements could impose on the county social and medical care programs that Congress itself would not approve.

NO BENEFICIAL EFFECTS FROM GG:

The AMA Washington Letter, No. 60

Gamma Globulin inoculations have demonstrated no beneficial effects, a Public Health Service sponsored committee of experts announces. The group, after evaluating nationwide data on last summer's inoculations, reports that: (1) Observation of communities where mass child inoculation was carried out, does not provide sufficient evidence to determine the efficacy of the serum in preventing the disease or alleviating its effects. (2) Mass inoculations usually occurred after the epidemic peak, thus reducing evidence of its effect on the epidemic. (3) Family-contact administration of the serum (where all household members were inoculated immediately upon recognition of a polio case) did not appreciably lessen subsequent family incidence of paralytic polio. (4) Inoculation of exposed persons caused no measurable difference in the severity of ensuing paralysis. (5) More experience and greater opportunity for scientific investigation is necessary for proper evaluation of gamma globulin in mass inoculations. The group, composed primarily of physicians, made its findings public after a three-day session at the PHS Communicable Disease Center in Atlanta, Ga.

Spokesmen for the Health Resources Advisory Committee of Office of Defence Mobilization said later that, "ODM is prepared to continue administering the distribution of gamma globulin for polio next summer, provided a satisfactory plan is agreed upon. . . But (regardless) there would seem to be no reason . . . why it could not be distributed . . . and used by doctors as they see fit."

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EDITORIAL

WILLIAM B. LONG, M.D.*

Our medical organization is rich in tradition, and active in medical education. Its headquarters represents organized Maryland medical activity with numerous and varied ramifications. The society is to be congratulated on the many services it renders Maryland physicians by regulating and policing proper medical standards; rendering assistance in medico-legal matters, and by disseminating general information through its journal.

The Society, however, has two glaring weaknesses which must be overcome if we are going to progress and become stronger and stronger in a country moving relentlessly toward a socialistic state. Weakness number one is our failure to sell the Society and its value to ourselves. County men still have the illusion of dominance of the Baltimore City Medical Society in the management and direction of the State Society. This is a very short-sighted view. I am sure it is a carry-over from the days when distances were relatively great, and transportation was both slow and inadequate.

This attitude is no longer valid with the Bay Bridge an accomplished reality. A quick look at the map reveals Baltimore to be almost in the center of the State. In addition, two great medical schools are located there. Certainly the faculties of those two schools should be well qualified to direct our policies since they represent the teachers of Maryland's future practitioners. I might add that the Society has plenty of work to distribute among those who show any interest in its affairs, whether it be city or county.

The second, and most outstanding weakness is our precarious and recurrently poor financial position. This seems both amazing and inexcusable in view of the fact that we look around each year for legitimate income tax deductions. Most of us contribute generously to all types of money-raising schemes on both a local and national level. In addition, we do not hesitate to join various medical groups that although providing excellent educational features, also provide an excellent opportunity to expend large sums of money for entertainment, travel, cruises, etc. This is certainly worthwhile and no one would argue against it, but why should our own organization suffer and struggle by attempting to operate with an inadequate budget.

Let us all do more in '54. Our dues and assessments should be more than adequate to cover current expenses and to build up a reserve to be used as needs may justify in any situation that could arise.



WILLIAM B. LONG, M.D.

* Member of the Editorial Board of the Maryland State Medical Journal and Council of the Medical and Chirurgical Faculty.

A MESSAGE FROM THE BAR ASSOCIATION COMMITTEE

WILLIAM D. MACMILLAN, ESQUIRE

The medical profession of today has a deep and abiding interest in good government in all its branches. The legal profession, recognizing this, believes the doctors of Baltimore City have more than a passing interest in the nomination and election of three Associate Judges of the Supreme Bench of Baltimore City whose names will be submitted to the voters in the June primaries.

Three of the candidates are now and have been officiating as Judges namely, Judge Joseph L. Carter, Judge James K. Cullen and Judge Emory H. Niles—all of whom have definitely demonstrated their Judicial qualifications. Their terms are expiring and to be retained on the Bench the voters must nominate them in the forthcoming June primary election.

It is to the very best interests of the public that a Judge of the Supreme Bench of Baltimore City should be appointed and elected on his Judicial qualifications completely apart from politics as such.

Only those persons "who are most distinguished for integrity, wisdom and sound legal knowledge" should be appointed or elected to Judicial office. The Constitution of Maryland so provides.

To that end when there is a vacancy on the Supreme Bench of Baltimore City, the usual practice is for the Bar Association, through its Judiciary Committee, to suggest a list of suitable candidates to the Governor. The Governor then appoints from among those on the list. The person so appointed thereupon is given the opportunity to demonstrate his qualifications until the primary election when his name is submitted to the voters. He is called a "Sitting Judge."

Perhaps there are some who do not realize just what the "Sitting Judge" principle means. In brief, it is the presentation of a Judge to the electorate *after* a testing period of one year or more. If the candidate has proven his judicial ability, he is endorsed by the Bar Associations and others for nomination and election.

To prevent, as far as possible, politics as such from entering into the election of a candidate to judicial office, the law now permits such candidate

to file in both the Democratic and Republican primaries and his name to appear on both ballots without party designation. This arrangement is limited solely to candidates for a Judgeship.

However, notwithstanding the foregoing safeguards which have been set up to keep the judiciary out of politics, there is still an opening for politics to creep in and that is because any lawyer, even though not approved by the local Bar Associations and without having previously functioned as a Judge on the Supreme Bench, may file as a candidate for that important judicial office. Certain such persons have so filed and hence are in opposition to the three "Sitting Judges": Judges Carter, Cullen and Niles.

Judges Carter and Cullen have been "Sitting Judges" for over a year and have clearly shown to possess all of the qualifications required. Judge Niles is completing more than fifteen years of very satisfactory service on the Bench but he, like the other two, must be voted upon in the June primary.

It is important for the medical profession to know that these three "Sitting Judges" have the endorsement of all four local Bar Associations: The Bar Association of Baltimore City, The Women's Bar Association, The Junior Bar Association and the Monumental Bar Association.

To quote a SUN editorial: "The system under which we operate is thus a fortunate combination of common agreement between the lawyers as a profession, the Governor as the appointing power and the voters in general."

The Bar Association Committee for the election of Judge Carter, Judge Cullen and Judge Niles recommends to you these three men who have established their judicial temperament, their sound legal knowledge and their integrity as Judges on the Supreme Bench of Baltimore.

The forthcoming primary election presents to the voters an opportunity to strengthen the Baltimore tradition of retaining proven Judges in office. The benefit of that tradition to the public is threefold: (1) it keeps judicial elections free of politics; (2) it keeps experienced Judges on the Bench; (3) it attracts well qualified men to succeed them.

Scientific Papers

SYMPOSIUM ON TUBERCULOSIS¹

Introduction

ROSS L. McLEAN, M.D., *Moderator*²

We will start off this evening with a discussion of bacteriology in tuberculosis by Mr. William Steenken, Jr.

BACTERIOLOGY IN TUBERCULOSIS

WILLIAM STEENKEN, JR.³

Mr. President, Members of the Society:

Tonight, I should like to concentrate on three bacteriologic aspects of tuberculosis which I believe are important and which, undoubtedly, will be discussed further by the panel. *

They are, 1) the place of the laboratory in the diagnosis and therapy of tuberculosis, 2) the question whether or not antituberculosis drug therapy can be definitive in the treatment of certain types of pulmonary tuberculosis, purely from the bacteriologic point of view, and 3) the phenomenon of tubercle bacilli that have become resistant to INH and lost their virulence—bacilli that are growable on artificial culture media, yet not capable of producing progressive disease in guinea pigs.

It is a well-known fact that the demonstration of unmistakable tubercle bacilli furnishes the most important criterion we have in the diagnosis of tuberculosis. Twenty-five years ago, no one would seriously have questioned the infallibility of a diagnosis based on the discovery of acid-fast bacilli in a sputum smear. Today, how-

ever, in the light of our knowledge of other acid-fast organisms which may be present in the sputum, it is necessary to employ more sensitive methods for demonstrating true tubercle bacilli, i.e., culture and guinea pig inoculation.

Many negative results of examinations of sputum smears for tubercle bacilli give the patient a false sense of security, but such apparently negative results often come back to plague the physician, unless repeated cultures of the sputum or gastric contents have been performed. In other words, to the bacteriologist, a negative sputum has little significance unless many successive specimens, sedimented, inoculated into animals and cultured, have revealed nothing. The value of one positive finding is absolute only when all the conditions of control have been fulfilled. Even repeated negative specimens are reliable only when related to other confirmatory evidence.

Today, the laboratory assumes a more significant role in the treatment of tuberculosis than it has in the past. You are all aware that in years gone by the therapy employed was bed rest, supplemented by pneumothorax, the phrenic nerve operation and thoracoplasty. The sole purpose of these methods was to alter the pathologic process which, in turn, affected the etiologic agent responsible for the disease. Today, however, the method of attack has been reversed. This is

¹ Presented before the Baltimore City Medical Society on Friday, December 18, 1953, at the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore 1, Maryland.

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³ Director, The Trudeau Laboratory, Trudeau-Saranac Institute for the Clinical and Experimental Study of Pulmonary Disease, Trudeau, New York.

largely due to the use of antituberculosis drugs which attack the etiologic agent directly. It becomes of prime importance to determine whether or not the organism harbored by the host is susceptible to the drug or combinations of drugs to be used in therapy. The method of ascertaining this information is to culture the tubercle bacilli from the patient—in the case of pulmonary tuberculosis, from the sputum—prior to and during drug treatment. The necessity for such sensitivity tests prior to chemotherapy will become increasingly important as more and more individuals become infected with drug-resistant tubercle bacilli. These tests also furnish the clinician with the data he requires relative to the *time* of emergence and the *degree* of drug resistance of the organisms during treatment, and thus guide in the selection of the drug regimen to be used or modified if and when such resistant tubercle bacilli appear.

At this point, I should like to state emphatically that until the general practitioner knows more about antituberculosis drugs and the employment of them in therapy—and this applies as well to the phthisiologist who does not have proper laboratory facilities for doing cultures and sensitivity tests—that patients should be sent to an institution where such facilities are available and where the proper drug regimens can be initiated. After chemotherapy has been established and the laboratory studies have been performed, the patients may then be sent back to their own physician to continue therapy. If, during home treatment, the patient is not responding to the drug, cultures of his organisms should be taken and sent to a reputable laboratory for sensitivity tests, the results of which will guide the clinician in determining the course of treatment to be followed.

The second point in this discussion is, can drug therapy be definitive from the point of view of the bacteriologist? Since the introduction of the new drugs, improved anesthesia and surgical techniques, the surgeon has been able to supply the bacteriologist with resected pulmonary lesions taken during life. These lesions are

often facetiously referred to as pimples; when more than one lesion is removed, the operations are called pulmonary manicures, and, more recently, I have heard them called nubbinectomies! Seriously, however, the excised lesion, when studied by the bacteriologist, has revealed some very interesting findings. Patients who have been treated with long-term combined streptomycin and PAS—one gram of streptomycin and ten to twelve grams of PAS every day—have yielded lesions that were originally cavities which had filled in with inspissated material, and when the lesions were smeared and stained they exhibited many acid-fast organisms. In fact, in some of the lesions there were large masses of stainable organisms, but they could not be recovered by any of the culture techniques we know of today, nor could disease be produced with these organisms in any of the susceptible laboratory animals. This is in contrast to the material that was supplied to the bacteriologist in the past. Formerly, it was necessary to wait until death of a patient before material was available for study. Needless to say, most of the lesions of the deceased contained viable tubercle bacilli by culture and animal inoculation.

The foregoing facts are no longer isolated findings, since many other institutions throughout the country are duplicating the original observations of the group at the Sunmount Veterans Administration Hospital which revealed that from the so-called “target” point lesions tubercle bacilli could only be recovered from ten to fifteen per cent by culture and guinea pig inoculation. The question arises, are these nonrecoverable organisms living or dead and are our present methods for demonstrating the viability of tubercle bacilli that have been under constant attack by drug therapy adequate? Personally, I still feel as I did four years ago when I first made the statement that the majority of the population of stainable organisms, nonrecoverable by culture or animal inoculation, in target point resected lesions are dead. Perhaps, by hard work, others may be able to disprove my assertion.

It has been maintained by some investigators that these so-called dead organisms, if put back into a nonimmune human host, would produce disease. Of course, it is impossible to do this. At the Trudeau Laboratory, however, we have produced chronic cavitary and discrete caseous tuberculous lesions in the rabbit and then instituted long-term chemotherapy. At autopsy, after long-term drug therapy, many of the lesions which were multiple throughout the lung contained numerous acid-fast organisms, and upon culture or animal inoculation, the viability of the tubercle bacilli was not demonstrable. The lesions were inoculated into the guinea pig, which is highly susceptible to bovine tubercle bacilli, and it was not possible to produce subinoculation tuberculosis. This should be a partial answer to those who believe that tubercle bacilli must be put back into human hosts in which the organisms produced the disease originally.

We now come to the third point, the question of tubercle bacilli that have become resistant to INH and lost their virulence—bacilli that are growable on artificial culture media, yet not capable of producing progressive disease in guinea pigs. This is a very interesting observation and the incidence of occurrence is certainly more pronounced in patients treated with INH than in those treated with streptomycin alone or in combination with PAS. Briefly, there appears to be a definite correlation between the loss of virulence and the development of INH resistance in some strains. We have not come across sensitive strains of tubercle bacilli that have lost their virulence for guinea pigs. However, all INH-resistant strains do not necessarily lose

their virulence for guinea pigs. I must emphatically state that although INH-resistant tubercle bacilli may lose their ability to produce progressive disease in guinea pigs, patients who harbor such organisms do have spreads revealed by x-ray and by clinical deterioration. It is quite evident that the incidence of spread and clinical deterioration is much more pronounced in the group of patients who were treated with streptomycin alone in the early days of the studies than in those treated with INH.

I think we should guard against statements that have been made to the effect that all one has to do is to treat a patient with INH, make his tubercle bacilli resistant to the drug and then the patient will no longer have a spread of his disease, nor will he be a source of danger to those with whom he comes in contact.

In conclusion, I should like to thank the Baltimore City Medical Society for giving me the opportunity to talk to its members. I trust that the three points which seem important to me from the bacteriologist's point of view, may help you in assessing the value of antituberculosis drugs upon the etiological agent, the tubercle bacillus, as well as the importance of the proper use of the laboratory in modern anti-tuberculosis drug therapy.

DR. ROSS L. MCLEAN: Thank you very much Mr. Steenken. I know that some of the members of the panel are "lying in wait" for you. I hope that some of the members of the audience are also. We will have our innings later on.

The next speaker will be Dr. Oscar Auerbach, Chief of the Laboratory Service at the Veterans Administration Hospital in East Orange, New Jersey, who has studied the morphology of tuberculous lungs very intensively for a number of years and whose findings with respect to the changes occurring in conjunction with chemotherapy have had considerable implications with regard to the chemotherapy of tuberculosis.

CHEMOTHERAPY OF TUBERCULOSISOSCAR AUERBACH, M.D.¹

Mr. Chairman, Members of the Society. When we first had the opportunity of studying the pathologic changes of tuberculosis following chemotherapy in 1947, we were impressed immediately by the fact that there were certain changes in the lungs following the administration of drug therapy, which were entirely different from those that had been seen in the pre-chemotherapy days. These changes, in brief, were the re-epithelialization of ulcerated surfaces of the larynx and intestines, the rapid clearing of perifocal reactions and the effects on the superficial surfaces of the body. As prolonged chemotherapy was used more prevalently and we had progressive chances of studying the pathologic changes, the differences in treated and untreated lesions of pulmonary tuberculosis became so striking to us that recently we have been making the statement that tuberculosis under chemotherapy is an entirely different disease than it was in the pre-chemotherapy days.

This last October five pathologists at the Sunmount Conference are reputed to have made a statement that the changes in the pathologic picture of the tuberculous lesions to which Mr. Steenken referred are no different from the healed lesions which we used to see in the days before chemotherapy. The Conference is quoted as having agreed, however, that the changes of healing were more accelerated in the post-chemotherapy than in the pre-chemotherapy cases.

Since the views expressed on that occasion are completely at variance with my own opinion, I wonder if I may tonight take the opportunity to present my findings and discuss the changes which I think are different, showing you comparable material which I studied in the days prior to, during, and after chemotherapy; later tonight I will show you comparable lantern

slides and let you judge for yourselves as to whether or not the changes are different.

The pathogenesis of pulmonary tuberculosis, as it begins, is the development of tuberculous pneumonia, generally in the infraclavicular area, which is no different from pneumonia caused by any other organisms except that there are tubercle bacilli present in this lesion. Around the area of pneumonia the so-called perifocal reaction forms, which was first described in 1905 by Tendeloo as collateral inflammation. This perifocal reaction differs from the original tuberculous pneumonia, which it surrounds, in that it contains no fibrin or polymorphonuclear leucocytes. As the process of tuberculosis develops, the area of pneumonia undergoes first red and subsequently grey hepatization and at this point differs only from the ordinary type of pneumonia in that it contains large amounts of fibrin and is somewhat more granular.

Subsequent to the stage of grey hepatization the pneumonic process goes on to caseation necrosis and at this point, surrounding it, a zone of tuberculous granulation tissue develops, which in turn is surrounded by the zone of perifocal reaction. The next step in this process is the further development of specific tuberculous caseation necrosis and extension of the area of tuberculous granulation tissue as well as organization of the surrounding perifocal reaction which becomes converted into a zone of connective tissue.

Subsequently the zone of necrosis may or may not take on calcium and the zone of tuberculous granulation tissue will be converted into a ring of hyalinized connective tissue which has been labeled "the specific capsule" because it arises from the previously intact tuberculous granulation tissue. The zone of perifocal reaction, in turn, becomes organized, as mentioned above, into loose connective tissue on its inner aspect

¹ Chief, Laboratory Service, Veterans Administration Hospital, East Orange, N. J.

containing compressed alveolar spaces lined by cuboidal cells, whereas its outer aspect usually undergoes absorption either through lymphatic channels or by direct transbronchial expectoration.

It is worthy of note that the so-called non-specific capsule, which if you will remember is the residual of the perifocal reaction, is wider in the lesions of reinfection tuberculosis than it is in those of the primary infection.

The area of necrosis may or may not subsequently liquify through the action of proteolytic enzymes and the presence of polymorphonuclear leucocytes which come into the zones of necrosis. Ulceration into an adjacent branch bronchus may take place and we now have an ulcerated bronchus leading into what has become a cavity and the basis has been created for the presence of continuous liquifaction of necrotic material, the expectoration of this material and the presence of a positive sputum. If no bronchial connection is established, the lesion remains as an encapsulated caseous focus. It is of interest to note that the original area of tuberculous pneumonia as well as the area of liquefaction is rhomboid or polyhedral in outline and that despite that the tuberculous cavities are round. This difference in shape is explained by the development of a ball valve-type mechanism at the bronchocavitary junction secondary to the presence of ulceration of the bronchus; this will allow the entrance of air into the cavity but prevent the evacuation from it and thus create some degree of tension mechanism within the cavity.

As the disease progresses the usual tuberculous cavity does not remain stationary, but continues in its course either through the rupture of adjacent new necrotic foci into the cavity, or progression of the process of necrosis and tuberculous granulation tissue from within the cavity. Each time, however, that progression of the tuberculous process takes place, a new area of perifocal reaction develops around the wall of the cavity. It thus becomes clear that the cavity wall becomes wide through organization of the

non-specific perifocal reaction. Thus in untreated cases of pulmonary tuberculosis one can readily recognize older as well as younger lesions by the width of the cavity wall.

Several other points are of interest in the pathogenesis of the chronic untreated, tuberculous, pulmonary lesions, and I would like to outline them separately, discussing each one in order.

First, the thickness of the cavity wall and the overlying pleura. The former point has been mentioned above and it is thus clear that as the cavity extends and perifocal reaction continues, both it and the specific tuberculous granulation tissue continue to become organized and the cavity wall ends up as a wide zone of connective tissue. Subsequently, as the process continues, it eventually reaches the pleura and the perifocal reaction, in turn, will effect this organ. Here again we have organization of the pleural perifocal reaction into connective tissue and thus the basis is present for progressive thickening of the pleura by fibrous connective tissue.

Similar focal changes occur also in otherwise encapsulated and non-liquefying, caseous foci and it can be seen that, despite the fact that ulceration and liquefaction do not take place, as the process of necrosis continues the perifocal reaction will also continue and the final capsule will be the end result of organization and fibrosis of this perifocal reaction and will be a wide zone of connective tissue.

As a result of the multiple episodes of perifocal organization and fibrosis there is a fibrotic process set up in the adjacent lung parenchyma with destruction of the same and as a result of contraction of the necrotic foci, emphysematous changes will take place in neighboring lung. Thus we can see that the final effects of the healing changes in chronic pulmonary tuberculosis are not only the presence of specific tuberculous alterations, but also of non-specific pulmonary fibrosis and emphysema.

You will all remember that in the prechemotherapy days there was a large incidence of fatal

cases of pulmonary tuberculosis through terminal pulmonary hemorrhages. In our series of autopsies, nine per cent of all pulmonary aneurysms had ruptured and in half of these we were able to find the aneurysms, whereas in the other half, only fatal extensive endobronchial hemorrhages were found, but the site of aneurysmal rupture could not be determined because the aneurysm had blown out completely.

In the untreated case of pulmonary tuberculosis the mode of cavity healing holds a great deal of interest. The aim of all therapeutic efforts had always been to collapse the bronchocavitary junction and thus allow obliteration of the bronchus at the site of ulceration. With the obliteration of the bronchus the cavity became a closed space, air was absorbed, the cavity content would inspissate and the result was closed healing of a tuberculous cavity. You will remember that many of these cases of successfully treated pneumothorax or thoracoplasty approach converted the sputum in the vast majority of cases and thus represented the closing of the bronchocavitary junction.

These are some of the basic changes seen in chronic untreated pulmonary tuberculosis, and now let us regard some of the alterations which are seen following chemotherapy. Clinically we find that the single and most dramatic effect of chemotherapy is the rapid clearing of shadows on the roentgenogram. This clearing of shadows, in essence, is the rapid clearing of the perifocal reaction and it is this process which is the basis for the alteration in the eventual pathologic picture of treated and untreated chronic pulmonary tuberculosis. In essence the perifocal reaction has been made to disappear from the perifocal alveolar spaces before it could be converted into connective tissue and create the damage outlined previously.

Now let us proceed to regard some of the further effects of this rapid clearing of the perifocal reaction. Probably the most important single effect is the markedly decreased degree of

organization and fibrosis of the capsule of the tuberculous focus, so that both cavity walls as well as capsules of non-liquefying foci are thin and rather delicate. This point, however, will only occur, naturally, if chemotherapy has been instituted sufficiently early in the disease to prevent the natural process from going on. If chemotherapy is postponed, for one reason or another, the distinction in the thickness of the capsule is no longer quite as readily discernible.

As a result of the decreasing size and more rapid absorption of the perifocal reaction in treated cases, also, the latter does not reach the overlying pleura and it should then be clear that pleural adhesions, pleural fibrosis and thickening is not nearly as extensive in chemotherapy treated cases as in those not treated. As a result of the decrease of connective tissue surrounding the foci, forming cavity walls as well as involving the overlying pleura and, secondarily, as a result of markedly decreased contraction of these foci, the degree of pulmonary fibrosis is markedly decreased. As an immediate result of this particular change there is a great deal less stretching and tearing of surrounding alveolar walls and the degree of pulmonary emphysema seen is markedly diminished.

As an immediate further result of the decreased amount of perifocal reaction due to more rapid absorption, there is a marked decrease in the number of pulmonary aneurysms and thus in the number of fatal pulmonary hemorrhages. Indeed it is rare at the present time to see a case of fatal pulmonary hemorrhage as a result of chronic pulmonary tuberculosis in a treated case. The reason for this, of course, is the fact that as the perifocal reactions continue they eventually involve the walls of pulmonary vessels, and as they begin to organize they involve these walls in a similar process of fibrosis and subsequent weakening of the vessel. This eventually will lead to aneurysmal dilatation and rupture. You can thus see that as the result of the decreased perifocal reaction, and the decreased fibrosis thereof,

there is a markedly diminished involvement of pulmonary vessels and the subsequent rarity of aneurysm formation.

Probably one of the most important effects of chemotherapy is the specific mode of cavity healing. You will recall that one of the early results found in chemotherapy treated cases was the reepithelialization of ulcerated surfaces. This process occurs at the bronchocavitary junctions and we now find in almost every case, in which we are able to search for it effectively, a process of reepithelialization by squamous metaplasia at the point of bronchocavitary junction. It might be of interest to note that prior to this period we were able to find this process of reepithelialization only in four per cent of cavities.

As a direct result of the reepithelialization the bronchocavitary junction remains open and the check-valve mechanism is broken, therefore allowing inspissation of the cavity from within and growth of a tuberculous granulation tissue with subsequent healing and fibrosis. Thus the cavity heals through continuous drainage and organization from within, although it must be said that a number of our cases have been found to have healed with continuously open cavities and a permanent bronchocavitary junction. In these cases of so-called "open healing" we now see a thin, well hyalinized connective tissue zone forming the inner wall of the cavity but find no evidence of an active necrotic process. The sputum, of course, in these cases will be negative.

These, now, are the points of difference, as I see them, in the pathologic changes of the treated and untreated instances of pulmonary tuberculosis. The point upon which there is general

agreement, and which is probably the most subjective of all, is the more rapid healing of the tuberculous foci under chemotherapy. I say subjective, because we well know that there are individual variations in healing. Thus, I would say that this point is probably the least important result of chemotherapy from a pathologic point of view. However, I do not think that there is any question that frequently there is a more rapid conversion of granulation tissue into hyalinized connective tissue as a result of chemotherapy.

In conclusion I would like to say that from our own experience we have observed the changes of the pathologic lesions of pulmonary tuberculosis to be different following chemotherapy than before it. Thus, our studies have shown that under chemotherapy the cavity wall, the overlying zone of fibrosis of the pleura as well as the capsule around necrotic foci are thinner. There is a marked decrease in the amount of pulmonary fibrosis and emphysema and the number of pulmonary aneurysms and hemorrhages is greatly decreased. In addition there is the previously described increase in the rate of cavity healing as well as an entirely different mode of cavity healing.

DR. ROSS L. MCLEAN: Now we will hear from the Chief of Medical Service of the Medical Department at Fitzsimons Army Hospital in Denver, Colorado. Those of us who are interested in chemotherapy of tuberculosis have long been interested in the results of the studies in chemotherapy of tuberculosis which have been published from the Fitzsimons Hospital. The tremendous interest that Colonel Tempel has put into these studies and the extreme care with which he has reported his material combine, I think, to lend more than the usual degree of reliability and confidence to his results. Colonel Tempel.

DEFINITIVE TREATMENT OF PULMONARY TUBERCULOSISCARL W. TEMPEL, COLONEL, MC¹JAMES A. WIER, LIEUTENANT COLONEL, MC²

In this Symposium on Pulmonary Tuberculosis a brief review will be given of the present day definitive treatment of this disease as practiced at Fitzsimons Army Hospital and comment made on three current problems that require further study; namely, hospital care versus ambulatory outpatient treatment, evaluation of long-term drug therapy and resection of small necrotic foci remaining after drug therapy.

The term "definitive treatment" as used in this discussion refers to those measures (rest, chemotherapy and operative procedures) directed primarily toward the arrest or cure of the local tuberculous disease of the lungs.

REST AND REHABILITATION

Proper isolation of the patient with recently discovered active and contagious pulmonary tuberculosis in hospital, rest therapy during the initial phase of treatment and a long period of properly supervised rehabilitation still constitutes the basic program of management of this serious disease. The patient undergoing definitive care is advised to remain on a hospital rest regimen until free of symptoms and the lung lesion is stable without evidence of cavitation for three months. As defined by 1950 National Tuberculosis Association (NTA) Diagnostic Standards this means "arrested disease." Ambulatory outpatient care begins when the sputum is negative for tubercle bacilli, the chest roentgenogram reveals a stable, non-cavitary lesion and there are no symptoms due to tuberculosis for at least six months. As defined by 1950 NTA Diagnostic Standards the disease is considered "inactive" at this stage. A return to a sedentary occupation (restricted duty) is advised six to twelve months thereafter and a completely

normal life (full duty) is usually permitted when the disease is inactive three or more years. This general plan of management was adopted by the Army in 1947 and has resulted in a high recovery rate with a relapse of the disease in less than 10% of all patients treated to the "inactive stage."

Since the adoption of long-term drug therapy, strict bed rest has been applied only during the early months of hospitalization or during the symptomatic and toxic phase of the disease. Bed rest is modified as soon as feasible to permit four hours out of bed daily for self care and limited educational and recreational pursuits on the ward. When the disease becomes "arrested" the patient is permitted out of bed eight hours on a semi-ambulatory status and privileges are increased to include passes and use of other hospital facilities (occupational therapy, educational, religious and recreational activities). Whenever possible the patient is hospitalized until the stage of "inactive disease" is reached in order to carefully evaluate the response to increased physical activity and to complete the rehabilitation program necessary for patients in the military service.

There are no documented reports in the literature on the ambulatory outpatient drug treatment of active pulmonary tuberculosis with long term follow-up studies, hence the evaluation of this treatment regimen must be deferred until various investigators can give adequate reports upon this matter. In the meantime, home care of patients with active tuberculosis should be considered at best a stop-gap which is full of pitfalls in the hands of any but experienced tuberculosis physicians.

CHEMOTHERAPY (ANTITUBERCULOSIS DRUGS)

The past two years have brought long term continuous drug therapy into prominence and demonstrated its superiority over short courses of chemotherapy. Because of the adoption of pro-

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² Chief, Tuberculosis Section, Fitzsimons Army Hospital, Denver, Colorado.

longed chemotherapy the attributes of a good regimen have been extended and we must now judge the clinical usefulness of any new drug combination in the treatment of pulmonary tuberculosis on the basis of the following criteria: (1) therapeutic effectiveness, (2) lack of drug toxicity, (3) minimal bacterial resistance, (4) ease of administration, (5) patient acceptance, (6) suitability for prolonged use and (7) reasonable cost.

Combined drug regimens have proven to be superior to the administration of a single antimicrobial agent in the treatment of tuberculosis (1) and the three best regimens investigated to date are intermittent streptomycin (SM) combined with daily para-aminosalicylic acid (PAS), intermittent SM combined with daily isoniazid (INH) or the combination of daily INH and PAS. Of these three combinations SM-INH appears to be the most useful at the present time. Some feel that SM and INH should not be used together routinely in the treatment of pulmonary tuberculosis because of the danger of losing one or both of these agents by reason of bacterial resistance. As an alternative it has been suggested that either be combined with PAS and thus preserve one primary agent. Much individualization is required in this consideration but experience at Fitzsimons Army Hospital would indicate that little danger exists in using SM-INH for patients having pulmonary lesions which may be expected to respond favorably in the first two years to a well integrated therapeutic program. Old chronic cases that may require several years of chemotherapy pose a problem and perhaps represent one group which would justify withholding one of the two effective drugs (SM or INH) for future needs. Reactions to PAS or serious intolerance to the drug when used for long periods sometimes occur and makes the combination of SM-INH the regimen of choice in such cases.

Duration of drug treatment: Lesions of recent origin showing prompt resolution may be treated successfully with a short course (8 to 12

months) of chemotherapy whereas new lesions with serious caseous pneumonic, necrotic or cavitory components will usually be deserving of a longer course (12 to 18 months or more of drug treatment). By long term drug therapy an attempt is being made to secure a definitive result with the antituberculosis agents and rest alone, or if this is not possible to so reduce the extent of the disease that the operative attack will result in a minimal loss of lung tissue and preserve pulmonary function to the greatest degree possible. The problem of duration of drug therapy is still under study, but most patients undergoing definitive treatment are given antituberculosis drugs until the stage of "inactive disease" is reached or longer. This appears to be a reasonable "therapeutic target date" for the use of chemotherapy, whether employed alone or as an adjunct to surgery.

Though the results of drug therapy are often dramatic, there is the general realization that it is frequently not definitive in a curative sense and must be integrated with an over-all program of bed rest, as well as medical collapse or surgical measures as the individual case dictates (Chart I).

OPERATIVE PROCEDURES

Temporary collapse: The need for temporary collapse measures in the treatment of pulmonary tuberculosis has been greatly reduced by specific drug therapy and advances in thoracic surgery, particularly pulmonary resection. Before collapse procedures are employed all patients receive at least four months of chemotherapy to reduce symptoms of fever, cough and expectoration, to promote resolution of consolidations and to relieve endobronchial disease with the associated danger of tension cavities, atelectasis and blocked drainage. Pneumoperitoneum has sometimes proven to be useful for cavitory lesions particularly in extensive bilateral disease both as a definitive measure and as an adjunct to prepare patients for surgical treatment. Drug therapy has reduced many of the complications

CHART I

The Definitive Treatment of Active Pulmonary Tuberculosis Based on an Estimate of the Lung Pathology

CLASSIFICATION OF LESIONS	MEDICAL TREATMENT	SURGICAL TREATMENT
	Specific drugs.* Temporary collapse	Pulmonary resection and/or thoracoplasty
1. Unclassified Lesions (new pts)	Start Rx on tentative classification. Use response to drugs for final plans.	
Reversible Disease		
2. Acute miliary tuberculosis 3. Chronic disseminated nodular tuberculosis. 4. Diffuse exudative tuberculosis	Reversible lesions are medical problems. Use continuous drug therapy until the inactive stage of disease. Operative procedures are not required.	
Irreversible—Poorly Resolving Disease: Acute or Chronic		
5. Acute caseous pneumonic tuberculosis	Medical measures (drugs and possibly pneumoperitoneum) are required for early phase of treatment and may prove definitive.	Surgery is considered after 6–12 mos of drug therapy for residual necrotic and cavitary lesions.
6. Chronic fibrocaseous tuberculosis (caseonodose and fibrocavitary lesions)		Old irreversible lesions are primarily surgical problems. Operate promptly when required and continue drugs 6–12 mos after surgery.
Mixed Reversible and Irreversible Lesions: Acute and Chronic Mixed		
7. Mixed Lesions Reversible exudative component: considered first Irreversible fibrocaseous component.	Treat as a medical problem with drugs and possibly pneumoperitoneum	If not controlled by medical management surgery will be required for definitive therapy

* Chemotherapy is used for all lesions to at least the stage of “inactive disease.”

formerly seen with artificial pneumothorax, but this procedure is rarely utilized at present and its final place in the treatment of tuberculosis must yet be evaluated. Operations on the phrenic nerve have been abandoned.

Thoracic surgery: Pulmonary resection is used much more frequently than thoracoplasty, the latter being employed chiefly with lobectomy or pneumonectomy as a space reducing operation. Except for lesions proven to be old irreversible disease suitable for immediate operation, most patients now receive protracted periods (6 to 12 months or more) of drug therapy prior to ex-

cisional surgery or permanent collapse and for similar periods after surgery (Chart I). The use of segmental and wedge resections for localized lesions has greatly increased during recent years because of this approach. The post-operative period in the hospital usually varies between six to twelve months depending upon the extent of disease found at the time of surgery and the requirements necessary to complete the rehabilitation program previously described.

The matter of long-term drug therapy as a definitive measure for localized necrotic pulmonary lesions versus surgical resection for such

residuals after drug therapy is a current topic of interest. Adequate follow-up studies of three to five years are lacking on large series of patients treated by drug therapy alone, hence no one can speak with finality on the subject. Resections for localized lesions have been used successfully at Fitzsimons Army Hospital since 1947 for cavitary disease, old relapsing lesions and large necrotic foci, particularly filled in cavities and tuberculomas 2 cm. or larger (2). Smaller lesions, both old and recent disease, have been treated by conservative measures and by surgical resection but the results of treatment by these two methods are not yet available for comparison. Although it is reasonable to believe that long term therapy may prove definitive for small non-cavitary residuals of pulmonary tuberculosis, experience with high relapse rates in disease of minimal extent before the use of chemotherapy justifies a cautious approach to this problem. The negative cultures for tubercle bacilli from non-cavitary tuberculous lesions resected after eight months of chemotherapy suggests promise for conservative treatment in this group, whereas positive cultures from persistent cavitary lesions make these foci a clear indication for surgery when such treatment is feasible.

CONCLUSIONS

The evaluation and treatment of patients with active pulmonary tuberculosis requires the cooperation of the chest physician, roentgenologist, thoracic surgeon, endoscopist, bacteriologist, pathologist, social service workers, educational counselors and other rehabilitation personnel and is best accomplished in specialized treatment centers. It must be remembered that tuberculosis is a contagious disease and in considering the place of treatment one must be mindful of the best interest of the patient's family and the welfare of the community.

The clinical and pathologic manifestations of pulmonary tuberculosis are so varied that any attempt to apply definitive treatment must take into account many factors such as cooperation, age, symptoms and general condition of the patient, amount of sputum, bacteriological findings, type and extent of pulmonary pathology, associated pleural and endobronchial tuberculosis, cardio-pulmonary reserve and response to previous treatment. Of these the most important consideration is the type of pulmonary pathological changes and the potentialities of the lesions to respond to various forms of therapy.

It should be emphasized that definitive (curative) treatment is only one of the five steps in the management of pulmonary tuberculosis, which includes (1) planning treatment, (2) the instruction and education of the patient, (3) general care and symptomatic measures, (4) definitive treatment, and (5) rehabilitation. Of all these steps the definitive treatment directed toward the cure of the local disease process in the lungs is probably the most important, but only by the most careful consideration of the entire problem of handling tuberculous patients can the present day management of this chronic, disabling disease be carried out successfully.

DR. ROSS L. MCLEAN: Thank you, Dr. Tempel.

We will go right along to the next speaker who is Associate in Surgery, Columbia University, Dr. J. Maxwell Chamberlain, who will discuss Resectional Surgery in Pulmonary Tuberculosis.

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RESECTIONAL SURGERY IN PULMONARY TUBERCULOSIS

J. MAXWELL CHAMBERLAIN, M.D.¹

Dr. Fort, Dr. McLean, Members of the Society:

Listening to Mr. Steenken, and Doctors Auerbach and Tempel was a great pleasure, but suddenly I realize that never before has a surgeon been in such an ideal position. Never before have I been able to join both sides. When a referring doctor shows me a case and says: "I think this lesion ought to be removed." I agree and take it out, and when he says: "Don't you think we ought to continue conservative management for another year?" I also agree, because I wish to work next year as well.

The surgical discussion to follow is based upon our experience with five hundred cases of segmental resection during the last six years. Three hundred of these cases have been followed from one to five years and ninety per cent of these cases had moderately advanced and far advanced lesions. In other words, ninety per cent of these patients had to have an anatomical segmental resection; almost always two segments. Only ten per cent required the so-called "snipping" operation, or "pimple-ectomies," as referred to by Mr. Steenken. Only ten per cent then were of such dimensions that it was possible to just resect them locally by enucleation or by wedge resection. I was very interested in Dr. Tempel's figures because he had 93.6 per cent good results, and, oddly enough, we have 93.7 per cent.

Of our patients after five years, 93.7 per cent are living and well. By that I mean (1) they have three negative cultures at least, (2) they have stable x-rays, and (3) they are either working or capable of working. So much for the moderately advanced and far advanced lesions on which our work was originally based.

The problem today, I think is the small lesion. Nobody seems to know the dimensions of "small," and very few of us know the dimensions of "large," and yet I am going to talk on the re-

section of the small lesion or the indications for resection of that lesion.

Often the question is asked, how small does a lesion have to be before it should be resected? If this question is directed to the surgeon, it is possible that these lesions can be almost microscopic in size. Seriously, we have logical ways of trying to get at this problem. I can't specifically tell you in centimeters the size of a small lesion that should be resected because there are many factors to be considered and these factors I am going to review with you for just a moment.

One of the factors, of course, is the *duration* of the lesion. If a patient comes in with his first x-ray without insight into whether or not he has or has had tuberculosis and cancer is suspected then, of course, the surgeon is anxious to consider the patient an immediate candidate for surgical resection. On the other hand, if a series of x-rays over the last ten years is available and no change in the size or the surrounding lung area is disclosed then the surgeon is less interested in an immediate resection.

Age of patient is the second factor which is important. Certainly if the patient has a small round lesion, is seventy-two years of age, the sputum is negative, yet the lesion is being discovered for the first time, then we are less interested in an immediate resection of the lesion. On the other hand, that same size lesion in the young, twenty-one year old male or female, who is in college, dancing, looking forward to marriage, a family, etc., a resection may be required. Such a patient is an excellent surgical risk. The patient's future security is better, and we allow him to live a normal and secure life by resecting the lesion.

Location of the lesion is extremely important. It has been pointed out by our pathologists that cavitary tuberculosis occurs in the upper aspects of the lobes and especially in the upper posterior aspects. The dependent part of the lobes and the anterior dependent part of the lobes do con-

¹ Associate in Surgery, Columbia University College of Physicians and Surgeons, New York City.

tain tuberculous foci but they rarely cavitate. Therefore, a lesion located in the dependent and anterior part of the lobe is less of a hazard to a patient than a similar sized lesion located posteriorly in the apical segment of the lower lobe. Location then is extremely important in one's decision.

Another factor is the patient's *personality*. Often in hospitals like Bellevue and occasionally in our Veterans and Navy hospitals we have an individual who has faced gunfire, is rather reckless, and not particularly frightened by his disease. He is not willing to accept the recommendation of his medical advisers and yet he is anxious to return to society. His last x-ray is the one he gets as he leaves the hospital. He has no follow-up x-rays during the next one or two years. His disease might reactivate and a large number of people could become infected. Sometimes, therefore, the patient's personality, his attitude toward his own disease and toward society may combine to influence our decision in favor of surgery.

The *number* and dissemination of these lesions may influence our decision. For example, often we find multiple round foci in both lungs. If on one side there are five, and perhaps six on the other, then we don't know which one of them is going to reactivate, or which one is going to liquify and shell out. I am not sure in my mind that it is justifiable to go in and take five out of one lung and six out of another in a patient whose sputum is already negative and whose disease pattern is considered to be stable.

Still another point is the number of *recurrences*. If this is the patient's first experience with the small lesion, I am inclined to feel he is entitled to at least a second breakdown. Certainly in some cases. But on the other hand, if this is his second or third hospitalization for the same lesion, and even though it may be a small one, he is probably better off with it removed.

The last indication has to do with *function*. In some of these patients their respiratory function is such that we are not able to operate on them. Excision of a "small" lesion in a patient with a very low respiratory function might lead

to a hazardous end result. A lesion of the same size in a patient who is young and with good function, we might easily resect.

If any of us in this audience should get tuberculosis, there are four things we would all hope for. The first is, we would hope for a cure; second, that we would be cured quickly; and third, that we would be cured without significant loss of function; and fourth, without deformity. Segmental resection is the one operation which most nearly fulfills all these four important criteria. That is why it has replaced other forms of surgical therapy and is the procedure of choice in patients who require a surgical solution to get well.

Finally, this one last thought. In this audience there may be someone who has had tuberculosis. He knows the anxiety of waiting for a monthly x-ray. He knows the sweaty palms associated with the tension of waiting for the x-ray to be developed. He knows the anguish of waiting the six weeks for that culture report to come back. He has had long hours at night lying in bed reviewing the future of his professional career. It appears that his career is concluded, that his family must suffer economically, that he has become, in a sense, ostracized from society, from his family and from his professional fellow-men. All this carries with it a psychic trauma which is immeasurable, a scar which cannot be seen in the chest x-ray. It is this psychic trauma associated with tuberculosis that we often overlook. It is this prolonged management, prolonged hospital care of the patient with tuberculosis that traumatizes permanently and perhaps irreversibly his future.

Dr. Churchill in defense of resection therapy once said that through prolonged medical care, through prolonged hospitalization, the patient's personality is often converted with his sputum. Therefore, as a surgeon, I should like to urge that we recognize these lesions early, treat them as outlined by Dr. Tempel and resect as quickly as possible significant residual foci which do not respond to conservative management.

Thank you very much. (APPLAUSE)

DR. ROSS L. McLEAN: Thank you, Dr. Chamberlain.

QUESTION AND ANSWER PERIOD

DR. ROSS L. MCLEAN: The members of the Panel have given us a very complete coverage in the field of tuberculosis, and I think that some of the very important points can be stated very briefly.

We have heard of the advances of long-term therapy. We have heard something of the effects of this long-term therapy with regard to the viability of the residual organisms, and also with regard to the stage at which the disease process may now be arrested.

We have had impressed upon us the absolutely essential requirement of eliminating cavitary disease and the almost equally essential requirement of eliminating large residual necrotic foci.

We again had brought forcibly to our attention the questionable status of whether organisms in residual lesions are alive or dead. Also, the question of whether small or even medium sized closed lesions should be resected. I think that we have again realized that the follow-up studies on patients who have received these long-term and seemingly successful courses in chemotherapy are yet to be presented to us. In other words, we do not yet know what the long-term results will be.

Finally, in addition to his surgical considerations, Dr. Chamberlain has most ably expressed what should be the concern of all of us with regard to treating the patient as a whole, rather than as an individual with a pair of infected lungs.

Now we have approximately ten minutes left for questions from the floor, and I hope that we will take full advantage of our ten minutes. Are there any questions from the floor?

Q. Have you seen cases of tuberculous meningitis develop in patients undergoing treatment with Streptomycin and isoniazid?

DR. TEMPEL: Such cases did occur when we were using streptomycin alone. As you know miliary tuberculosis and meningitis frequently complicate the treatment of ordinary pulmonary tuberculosis, but I have not seen a single instance

of meningitis developing in patients receiving isoniazid.

Q. The reason that I ask you this question is because in our Children's Hospital we haven't noticed tuberculous meningitis when we treated with this regime. That brings up the question. What do we do with our kiddies under two years of age who have the first infection of tuberculosis. Now, of course, the consensus of opinion is that we should not treat them at all and just let them alone, as you know. If it is true that tuberculous meningitis will not develop, one wonders whether we are justified in treating those kiddies with streptomycin isoniazid. I am just raising that question with the idea of preventing tuberculous meningitis.

DR. TEMPEL: We have thirty beds for children and I would say all of our patients with primary tuberculosis are treated with streptomycin and isoniazid. Of course these patients came to us because they had recognizable pulmonary lesions. Your question probably refers also to children who have converted tuberculin test only. Is that right, Sir?

Q. Well, I am referring primarily to the kiddies under two years or three years of age, more or less under a two year age period where they are very susceptible to tuberculous meningitis.

DR. TEMPEL: I would think it would be reasonable to treat this group with antituberculous drugs as a prophylactic measure. I would advise it.

DR. MCLEAN: Thank you very much. May I suggest to those who rise to question, please state your names so the members of our Panel who are not familiar with many faces here will know whom to address. Are there further questions?

Q. Would Colonel Tempel treat any of his patients more than twelve months? It seemed to me that from his reports he didn't show any cases that were treated over twelve months.

DR. TEMPEL: Yes Sir. We would treat every case undergoing a definitive treatment program until the lesion is "inactive." This means that

many receive eighteen months, two years or more, of drugs. We have had ninety patients with miliary tuberculosis and meningitis, and in this group the average duration of treatment was eighteen months. Treatment is based on stability of the lesion, cavity closure and sputum conversion. These conditions should be present no less than six months before drugs are discontinued. In other words, this meets the new National Tuberculosis Association standard for "inactive disease."

Q. DR. FISHER: I'd like to ask Mr. Steenken something more about the results of the isoniazid-treated patient. He said, I think, that some tubercle bacilli recovered during treatment, were resistant to isoniazid and were found to be avirulent for guinea pigs. I wonder if he would say something more about that, the ones that are resistant to isoniazid?

MR. STEENKEN: I had intended to cover that subject in my talk but it would have taken the entire evening. However, I think this is a very important question and I am glad you raised it. It is true that we are finding isoniazid-treated patients whose tubercle bacilli are resistant to the drug, and that many such organisms lose their ability to produce progressive tuberculosis in guinea pigs but will grow on culture media. We have made some studies to determine if the attenuation is a true bacterial mutation such as occurred with the bovine strain BCG (*Bacillus Calmette-Querin*) in which the growth characteristics are those of a rough avirulent type. From our limited studies, it appears that the colony growth characteristics of isoniazid-resistant tubercle bacilli are the same as the virulent isoniazid-sensitive pre-treatment organisms. Therefore, it would seem to be a different type of mutation.

All isoniazid-resistant tubercle bacilli do not necessarily lose their ability to produce progressive disease in guinea pigs. A suggestion, which I believe emanated from Denver—not from Fitzsimons but from the National Jewish Hospital—is that the ideal thing to do would be to make the tubercle bacilli of all patients resistant to iso-

niazid. Thus, these organisms would lose their virulence and be harmless to the host harboring them as well as to others coming in contact with them.

At Trudeau and Sunmount, we have seen patients whose organisms have become resistant to isoniazid and lost their virulence for guinea pigs, whose lesions have remained stable for a time but eventually showed x-ray spread. We are following these patients to see whether their organisms will regain their virulence. It is a very important phenomenon to follow. The U. S. Public Health Service is running a controlled study in which all the cultures are sent to Trudeau laboratory for virulence testing, prior to and during chemotherapy. At Trudeau, we do not know what drug regimens the patients are on, nor anything about the x-ray or clinical status of the patients. We send the results of the tests directly to Washington where they are compiled and analyzed, and certainly should give an impartial answer.

Q. As I understand it, there are some experiments in which isoniazid-resistant organisms did *not* produce disease in guinea pigs but these same organisms injected into mice *did* cause disease?

MR. STEENKEN: I believe that finding may be open to question for the reason that the mouse had been infected intravenously whereas the guinea pig had been infected subcutaneously. At present we are running an experiment comparing guinea pigs and mice which were infected subcutaneously and intravenously, the infecting dose being calculated on a body weight basis. Until such experiments have been completed, we must be cautious in our interpretation of comparative virulence studies of tubercle bacilli in various animal species.

DR. ROSS L. MCLEAN: I am afraid that on that note we must close. It has been a pleasure for all of us on the Panel to have appeared before this meeting this evening, and I will now turn the meeting over to Dr. Wetherbee Fort, who will close.

DR. WETHERBEE FORT: I just want to say we are deeply grateful to all these gentlemen for their kind efforts in our behalf. The meeting is adjourned for buffet supper downstairs and I wish a Merry Christmas to you all.

(APPLAUSE)

JUVENILE DELINQUENCY AT THE REFORMATORY LEVEL

JOSEPH LERNER, M.D.^{1, 2}

The recurring publicity being given to juvenile delinquency has begun to cause the public to take a more active interest in the problem despite the fact that delinquency has been with us in some form from the very beginning of social behavior. Greater public interest has been in part the result of publicity, especially when the newspapers have no other means of stimulating circulation. As James J. Walker, former Mayor of New York, so aptly put it, "All bad news is good news for the newspapers." Reading the gory details of juvenile delinquency sells newspapers, even though it is obvious that the suggestibility of a large segment of our population makes such publicity contrary to public welfare. The recent account of the deformed personality who murdered his mother and father by getting them to drink cyanide in their champagne is a rather grisly example of how these psychopathic currents in our society are being brought to the surface for public observation.

It is a curious fact that more has been written about juvenile delinquency in the last twenty years than all of the written knowledge of the whole world that was available in the time of Aristotle. Furthermore, the improvement in living conditions of our children in the past twenty years has been greater than ever in the history of the world. Housing, nutrition, recreation, and health standards have reached a peak that would have been the envy of royalty a thousand years ago. We are spending more money per child in our school facilities than ever before, and we have had the benefit of progressive education for more than a generation. We

have even reached a point where parents will protest because their children walk an extra fifty feet to board the bus that takes them to school. In spite of all of these advantages, juvenile delinquency is very much with us. This inconsistency is especially striking when we consider other aspects of our civilization as for example, agriculture, where the tremendous improvement in our methods has resulted in tremendous improvement in the quality and quantity of our agricultural products; yet, when it comes to our children, we are confronted with the paradox of poor results despite what appear to be improved methods and means.

It has been generally held, from a psychological and psychiatric point of view, that when a given personality is unable to adjust to his environment, he either follows a neurotic pattern in which his aggressiveness is turned against himself, or he follows an antisocial pattern and turns his aggressiveness against society. In actuality, however, we find that most juvenile delinquents have both neurotic and psychopathic traits, and for purposes of classification we can divide them into the following groups: (1) those with predominantly neurotic patterns with antisocial effects, (2) those with strong antisocial patterns with little or no evidence of neurotic tendencies, (3) the mixed type, where we find severe neurotic patterns associated with severe psychopathic traits. The following cases illustrate these types of antisocial behavior and delinquency.

CASE REPORTS

I. P. J. M., aged 25, born in Virginia, single. He is the second of three living children. Father was a Colonel in the U. S. Army, and the patient was born on a military reservation and traveled extensively in his early childhood. Since 1942 he

¹From the Maryland State Reformatory for Males, Breathedsville and the Riggs Cottage Sanitarium, Ijamsville, Maryland.

²With the technical assistance of Herbert Sigel, Psychologist, and Miss Elizabeth Gilbert.

has resided fairly regularly on a 250-acre tobacco farm owned by his mother. He attended a military type of prep school and had a year of college education. In recent years he worked about the farm and used a large assortment of modern power driven machinery. He began to gamble in 1951 and also drank heavily. When he lost so much money, he began to break into service stations and other places and in all committed about fifteen robberies before he was finally apprehended and sent to the reformatory for a period of three and a half years. He explains his stealing on the basis that he needed money in order to have a good time at the races, and after a while he began to enjoy stealing which represented a source of satisfaction to him, even above and beyond the money that he stole. There is a suggestion of emotional coldness about him and he himself has not made friends very easily. His interest in the opposite sex is very limited, and his social life was almost exclusively that about the race tracks. His delinquency shows clear cut roots in an emotional pattern of emotional immaturity and impulsiveness which are related to failure to acquire adequate patterns of behavior in childhood.

II. O. W. S., Jr., aged 26, born in Maryland, single, completed the ninth grade. In 1943 he was put in the Maryland Training School for delinquency. While in the U. S. Army he served one year at the United States Naval Disciplinary Barracks, Norfolk, Virginia, for an assault on a commissioned officer. In 1950 he was arrested for fighting and was intoxicated; 1950, drunken and disorderly; 1951, vagrancy, and in addition had three more sentences in the Baltimore City Jail for being drunken and disorderly. His present sentence of 15 years was the result of robbery with a deadly weapon. This, too, was while he was intoxicated. He was 7 years old when his parents were divorced, and he lived first in one home and then in the other. Bellevue Intelligence Test showed him to have an I. Q. of 123 and he was rated as superior general intelligence. While in school he was in the Division for Special

Education and was described as being disobedient, impertinent, and contradicts everything that is said by teachers. While in the Maryland Training School he is accused of having been very uncooperative and attempting immorality with boys in the Cottage. His father has always been a gambler and made his living doing so.

He voluntarily came in for examination and treatment because of what he describes as "impotence." He is able to have an erection but cannot have an ejaculation with a woman. This has been present since his puberty when on a few occasions he was successful, but not since. He states that women complain because he takes so long. There is a vague history of homosexuality but this was not confirmed at this time. He has been unable to handle his sexual problem satisfactorily, and his drunkenness and his antisocial behavior are directly related to the strong emotional storms resulting from this sexual disability, which in itself is on an emotional basis. Any attempt at rehabilitation would have to assure this young man of psychiatric treatment if such efforts at rehabilitation are to be successful.

III. R. A. B., III, aged 18, single, completed the 9th grade. He was committed for larceny of an automobile and has done this on a number of occasions, but, after being apprehended, the charges were dropped as a result of his family's pressure. His persistent delinquency finally exhausted even his family and he was eventually confined in a custodial institution. His father and mother were very solicitous about him, and it is obvious that he was spoiled. He recognizes his lack of self-control regarding his social adjustments but shows no inclination to improve his self-control. His I. Q. was reported as 122, and the psychologist stated that his delinquency was directed toward demonstrating his own importance and capacity. He is extremely impulsive and shows a lack of emotional warmth which is related to his inadequate social adjustment and delinquency.

IV. R. I. F., 21 years old, single. He is the

younger of two sons and his family live in comfortable circumstances. He completed the 10th grade at the St. Martin's Parochial High School. His work record was poor. He makes a very good impression, being quite pleasant and verbalizes very well. He tends to blame his delinquent behavior on the fact that he was spoiled, and he appears to delight in being in trouble as an expression of his hostility toward his parents. He feels they have favored his brother over him. He is very impulsive and tends to behave in a delinquent manner as an expression of his desire for attention and being considered a tough guy.

V. J. E. L., II, 20 years old, single, the oldest of three living children. Family life was unsatisfactory. His mother worked in night clubs and he appears to have been a neglected child. He is described as being very dull in normal intelligence and has an I. Q. of 83. His record in school was that he was a chronic truant and was in several institutions because of his unwillingness to attend school. He committed a number of acts of larceny and was in a custodial institution previous to admission here after he was convicted of burglary. While here, he was hospitalized because he cut his wrist in a rather superficial manner, and he is described as being very impulsive and easily influenced by others. He is constantly in trouble in the Reformatory as he seems to delight in breaking the regulations and shows little capacity to learn from his experience, and punishment does not serve to deter him from his antisocial behavior.

VI. J. E. C., aged 24, has a long history of delinquency and a very poor work record. Comes from a family background of social deprivation. Has been in constant trouble in the institution because of frequent infractions of the rules. He asked for an interview with the psychiatrist and complained that he had been having frequent nocturnal emissions associated with dreams in which he is having sexual relations with the women in his family, including his own mother. These activities are perverted and sometimes his mother turns into his grandmother at the time

of his orgasm. "There is something wrong with me and I admit it. Sometimes I masturbate and that same night I still have one or two wet dreams. When I work and get some money, I go around to the bars and night clubs. When I pass cars with stuff in, then I break in the cars and get this stuff, especially when there is a big crowd passing by. It gives me a thrill when there are so many people around. I want to get caught because I have the feeling to steal and when I get arrested, I know I won't be able to steal anymore." When discussing his disturbing dreams, he talks about it with a smile on his face. He shows very little real concern about his problems and has a perverse attitude toward social standards, which results in his persistent delinquency.

Most of the juvenile delinquents at the Maryland State Reformatory for Males have usually been confined in other custodial institutions and reached the Reformatory after other efforts at rehabilitation have failed. Many of them are severely neurotic and their delinquent behavior is a direct outgrowth of their emotional disturbances. As Guttmacher puts it, they are for the most part unhappy persons harassed by tension and anxiety; and when the anxiety reaches to a certain pitch, they seek relief through some antisocial act and characteristically show a repetitive pattern. Lauretta Bender tends to attribute the delinquent behavior pattern to an emotional deprivation during the infantile period due to a lack or serious break in the parent-child relationship. I am frank to say that up to the present time there is no basis for believing that there is a valid explanation for the development of all juvenile delinquency, and some cases have no scientific explanation. There are many instances where one child in a given family group, under excellent conditions, becomes delinquent, even though his brothers and sisters raised under identical conditions are able to make adequate social adjustments. There are even instances where one of twins becomes

delinquent while the other makes an adequate social adjustment.

In the neurotic delinquent we find a genuine understanding of and desire to adhere to the moral code of our society, but his ability to follow an adequate social and moral pattern is so strongly affected by his emotional turmoil as to result in delinquent behavior. In some instances, as case #I, the general let-down in the moral tone of our society has led some individuals into undesirable types of behavior. This is aggravated by the growing tendency to shrink from corporal punishment or physical pain as a means of holding emotionally conditioned behavior in check. The pendulum has swung from the indiscriminate use of the policeman's club to the other extreme where every criminal and delinquent is protected against physical mishandling. Some years ago, in Philadelphia, the victim of an intended hold-up drew out a pistol and shot one of the highway men. The highway men protested, "He had no right to carry a gun." The unwillingness of the public to accept brutality has led to an unwarranted softness in the handling of delinquents, so that coddling of delinquents has become the order of the day. It should be clearly understood, of course, that brutality is not a cure for delinquency but, on the other hand, neither can coddling contribute to adequate emotional self-control. The answer lies somewhere between the two extremes, but it is unfortunate that our public officials are not willing to stem the tide of this growing insistence on humane treatment to the point where it has become merely an index of our cultural softness.

Another facet lies in the amazing number of people who have children but have neither the ability nor the willingness to furnish those children with an adequate environment, with the obvious result that their offspring are all too frequently found as delinquents, if not criminals. This is purely a social problem for which no legislation of itself will ever furnish a solution. Real progress will only be made when our educational system can begin at the roots of the

problem; that is, the parents. Their emotional attitudes are the prime factor in the steady tide of delinquency which is now facing us.

In addition to the large number of delinquents who show emotional patterns which are causally related to their delinquent behavior, we have a small percentage of what we may call true psychopaths, who show marked antisocial behavior with little or no evidence of significant neurotic patterns. Our delinquents are mixed with these prisoners and exposed to their influence. These real criminals cannot be considered as being emotionally ill, even in a broad sense, but have a deformed moral code which develops as a result of improper or inadequate social patterns which are acquired from an environment lacking proper family and social influences. These individuals have a faulty character development so as to render them incapable of adhering to a satisfactory social pattern, and, as lawbreakers, they prey on society. With their defective capacity for ethical behavior they cannot learn from experience, or even loss of liberty, to adhere to acceptable ethical standards. Their emotional patterns are shallow and by and large make no significant contribution to their delinquent behavior. They can make superficial explanations for their behavior, but fundamentally they are unwilling to follow the accepted rules of moral behavior and find their greatest satisfaction in bucking the current of social restriction. Their abnormality is not an illness but a defect of social adaptation. This is, of course, contrary to the opinion of Abrahamsen who says, "When men break the law they are giving expression to mental illness." He has extended the concept of mental illness to the point where it has no meaning. Violation of the law today all too frequently is a technical violation rather than a moral violation. Furthermore, the legality of behavior varies with time and culture. As Guttmacher declared, there is no validity in the classification of all lawbreakers as being mentally ill.

In our experience, the most fruitful field at

efforts at rehabilitation lies among those whose delinquent behavior is in a large measure the result of emotional disturbances. These individuals can be and are being helped by a psychotherapeutic approach which is geared to their intellectual and social background. It is essential that we provide more facilities to give these delinquents sufficient insight into their emotional problems if our efforts at rehabilitation are to have any value. Lemkau emphasizes the fact that if we are correct in believing that there are emotional factors which are the cause of disturbances of behavior, then it is our responsibility as mental hygienists and psychiatrists to find a way of altering the dynamic complexes of members of the population so that disturbances will not result. This may, at first, be an expensive program since it would involve the use of more psychiatric and psychological personnel, but on a long-term basis the state would find it much less expensive than to continue to merely incarcerate these individuals indefinitely.

In addition to the need for more professional assistance, there is also a definite need for an increase in the physical facilities so that better classification and segregation can be provided. In the Maryland State Reformatory the physical facilities are magnificent but they have not kept pace with the growing numbers of delinquents committed there, so that proper classification and segregation have been impossible. As a result of overcrowded conditions, neurotic delinquents are in contact with ordinary criminals so that they are exposed to influences which retard and interfere with their chances for rehabilitation. This same lack of space involves inadequate recreational facilities, resulting in idleness and in a poor atmosphere in which to try to help these young men handle their emotional problems more satisfactorily. This condition is being corrected in the State of Maryland by the construction of the new institution at Patuxent. This will not only furnish needed physical facilities, but it

will provide a thoroughly scientific approach to the problems of juvenile delinquency so that Maryland will be in the vanguard of those states using the most modern methods for meeting this challenging problem.

Another important problem is to have a better liaison between the psychiatrist, the psychologist, the parole officer, and the social service agency. All too frequently the parolee is lost in the shuffle and loses his contact with those with whom he has established an adequate therapeutic relationship. Without this beneficial influence he is far more prone to mishandle his emotional problems and soon turns up as a repeater. The need for a psychological and psychiatric out-patient approach to the handling of parole problems is one which is so obvious that it hardly needs to be mentioned. The expense involved would more than pay for itself on a long-term basis.

SUMMARY

Some case histories are cited to illustrate the presence of strong emotional factors as an etiological background for the pattern of delinquency. Several cases illustrate the presence of severe behavior disorders with little or no neurotic background. These cases are mixed indiscriminately as a result of a lack of physical means to adequately segregate them. The need for increased psychiatric and psychological help for delinquents is emphasized, and Maryland's progress in this regard is pointed out.

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Component Medical Societies

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Correspondent

At this writing for the May Journal, the very well attended March Meeting has just been held. President Gundry started it right on the dot at 8:30. Late arrivals came until after 9:15 and filled Osler Hall. Red carnations—token of “Doctor’s Day”—were a pleasant thought and gave the assembly a festive air. It is nice to be so remembered. Many thanks to our ladies, to their president, Mrs. Thomas Webster, Mrs. Arthur York—Hospitality Chairman, and Mrs. E. Roderick Shipley, President-elect—who were there and actually did the “pinning-on.”

Several business items were taken up: criticism of the Constitution approved last Fall resulted in extended proofreading. Doctor Moses Paulson, Chairman, and the Constitution Committee edited out inconsistencies and bettered phraseology. The changes were approved sight unseen, a high water mark of some sort for faith, inertia, or both.

A mandate to the City Society’s delegates to the Faculty at the coming State meeting that they vote for the Amendment with regard to the Building Fund was ably sponsored and carried through by Doctor Goldstein, Chairman of that Committee. His point of view that unless doctors pay for the building themselves, unless it means something of a doctor’s own money, the building will not have personal value and will never be theirs, was approved by the full-house meeting and was the determining sentiment.

Opinions were aired regarding the action of the Committee on Public Medical Education and the Executive Board with regard to a “Question and Answer Column” for the public papers of Baltimore. Past-President Chesney stated the case for abstaining and Vice-President Koontz gave the reasons behind the action as a step to better public relations. He explained the precautions to be taken so that the topics answered were to be kept within proper bounds. The sentiment of the large meeting seemed to be with the action taken. Particularly when it was

brought out that the service had been offered gratis to both papers, accepted by only one. The question was not put to a general vote. Certainly it seems a proper step toward better public relations. If some of the irregular cults were to provide such a service after the City Society refused, it would not be good. I believe, as Doctor Chesney himself once said, when the Blue Shield matters were under feverish discussion, “If we do not trust the integrity of our own members, where are we?”

Formation of a Section on General Practice was authorized by vote. The development of this group as an organized Section will be awaited with interest. As with the Internists who organized last year, the group formation should be for economic protection with regard to insurance and Blue Shield status. The need for economic safeguards for medical groups has made the formation of such protective Sections almost mandatory. The formation of the Sections on Internal Medicine and General Practice, too, is in line with the awakening interest of the American Medical Association in their problems. These groups will be in a position to cooperate and work with the headquarters of the A.M.A. as plans are formulated and inequities corrected.

The panel on “Uses and Abuses of ACTH and Cortisone” devoted most of its time to the “Uses” rather than the “Abuses.” Each speaker presented his topic well. The usual difficulty of keeping speakers to their time limit was encountered. It is regrettable that the meeting lasted so long that no formal question-and-answer period was possible. The large audience had been enthusiastic and responsive.

BALTIMORE COUNTY MEDICAL ASSOCIATION

SAMUEL P. SCALIA, M.D.

Journal Representative

The March luncheon meeting of the Baltimore County Medical Association was held March 17, 1954 at the Stafford Hotel in Baltimore City.

One of the annual activities of the Woman’s Auxiliary to the County Medical Society has been a

health project booth at the Timonium State Fair. The problem each year has been one of personnel, not enough women to take care of the booth. Dr. Wilmer Gallager, adviser to the ladies group, asked for an opinion from the Association. After some spirited arguments pro and con, it was decided that Dr. Warthen probably presented the best solution to the problem. The County Healthmobile will be stationed on the fair grounds taking chest x-rays and publicizing our fight against tuberculosis. The Healthmobile will carry a sign stating its sponsorship by the Baltimore County Medical Association, the Baltimore County Public Health Association, and the State Department of Health.

A letter was read from the Medical and Chirurgical Faculty concerning the plans for renovating the Cathedral Street building. The fund is still short of its goal by several thousand dollars. It was suggested to the County physicians that they may be assessed \$100.00 apiece to help in attaining the necessary funds. The Board of Governors is to investigate the soundness of this assessment.

Dr. Warthen announced that Montgomery County has been chosen for the polio field trial. Baltimore City and County are not participating, but all physicians are awaiting the results with interest.

Dr. R. Walter Graham, Jr., was the guest speaker for the March meeting. His talk concerned the controversy between the Veterans Administration and the American Medical Association regarding medical care for the veterans. The AMA positively approves of medical care of any service-connected disability. It also approves of temporary care of veterans with tuberculosis or neuropsychiatric disorders. It does not approve of medical care for any disability that was not incurred during military service during war or peace time.

The Veterans Administration has grown to unbelievably tremendous proportions. In size and expense the VA is second only to Great Britain's Nationalized health program. There are at present

about 20 million veterans in this country. The veterans list increases at about the rate of one million per year.

At the present time, the Veterans Administration maintains 154 hospitals with an average capacity of 759 beds per hospital. Their hospital program is still expanding. The VA maintains three times the number of beds necessary to care for service connected disabilities. As of June 30, 1953, there were 22,000 people on the waiting list for admission to a VA hospital. Only three of these had clear cut service-connected disabilities.

The average hospital stay is 30 days in a VA hospital as compared to 7 days in a civilian hospital. This is related to the red tape, to extensive and often unnecessary studies and to prolonged treatments given to the veterans. This is no reflection on the professional personnel, but many of the studies and much of the treatment could be performed out of the hospital. Over 4,000 physicians are working for the Veterans Administration. This, of course, is further helping to create a false physician shortage for our civilian population.

All that a veteran has to do to enter a VA hospital is to sign an oath in which he states that he cannot afford private medical care. The veteran is not investigated to prove the validity of his oath. Spot checking has disclosed that many veterans are well-salaried and have large estates. The files of the veterans and of the hospitals are considered confidential by law and no one can get to them. Every state medical society has a committee whose function is to establish liaison with the VA hospitals but since the hospital files cannot be examined, the committee is stymied.

The AMA and all its component groups is petitioning Congress for legislation to change some of the inequities in the VA laws. It is felt that as the veteran population increases, it will be a short step for the government to include the veterans' families for medical care. This certainly is the back door to socialized medicine.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

THE EDGAR B. FRIEDENWALD COLLECTION

MARY EMILY BERGE*

Dr. Edgar B. Friedenwald recently made a handsome gift to the Library of the Medical and Chirurgical Faculty when he turned over to us his collection of books on the history of pediatrics, the fruit of over forty years of collecting.

Dr. Friedenwald has been a member of the Medical and Chirurgical Faculty and the Baltimore City Medical Society since 1911. He is one of a family, long distinguished as physicians and scholars, who have rendered great services to the Faculty. His father, Dr. Aaron Friedenwald, was president in 1889, and his brother, Dr. Harry Friedenwald, served as president in 1923.

Dr. Edgar Friedenwald was graduated from the College of Physicians and Surgeons of Baltimore in 1903. One of his teachers was Dr. John Ruhräh who awakened his interest in pediatric history and was a constant source of help and inspiration. It was upon Dr. Ruhräh's advice that he entered general practice in one of the mining sections of West Virginia following his internship. Dr. Friedenwald says he went through everything there "including a small-pox epidemic!" But he adds, "It was an invaluable experience for which I shall always be thankful."

However, his real interest was in the care of children and he decided to specialize in pediatrics. He took his family to Germany where he studied at Finkelstein's Clinic and at the Charité of the University of Berlin. It was in Berlin in 1910 that he began the collection which he has presented to us. The book which formed the nucleus of his library, appropriately enough, was a German edition of Rosen von Rosenstein, published in Hamburg in 1767. Rosen von Rosenstein, it has been said, laid the foundation of pediatrics as a specialty.

Upon his return to the United States Dr. Friedenwald began his service to the children of Baltimore

* Assistant Librarian.



EDGAR B. FRIEDENWALD, M.D.

which continued until his retirement in 1950. He was chief of pediatric service at Mercy Hospital for many years, interrupted only by brief service in the Army during the Mexican War. He was also professor of clinical pediatrics at the University of Maryland Medical School.

Dr. Friedenwald has a fund of fascinating stories about medical lore, physicians, health progress and child welfare in Baltimore and Maryland. He remembers as a boy how his father kept nanny goats in the back yard because the milk offered for public consumption was so contaminated it was unfit for children to drink. He remembers when the mortality rate at St. Elizabeth's Home for children was almost fifty per cent. He is proud of the fact that when he became physician to the Home, he was able to cut

it down by half in his first year of service. Since his retirement, Dr. Friedenwald has been engaged in writing a history of pediatrics in Maryland and Baltimore so we can hope to see some of his stories in print.

Dr. Friedenwald has been able to repay his mentor, Dr. Ruhräh, for past kindnesses. When Dr. Ruhräh was compiling his anthology, "Pediatrics of the Past," Dr. Friedenwald lent him books from his collection which Dr. Ruhräh did not have. In fact, Dr. Ruhräh had photostats made of some of the title pages in order to use them as illustrations in the book.

Dr. Friedenwald's collection consists of nearly two hundred books. They represent many great names and a number of lesser lights in the history of pediatrics. The collection includes copies of Mercurialis, the German edition published in Frankfurt in 1584; several editions of Walter Harris; the Heberdens; Michael Underwood; Armstrong; as well as Nicolaus Fontanus. The first edition of the latter was published in Amsterdam in 1642. As Still points out, it is an interesting illustration of the literary habits of the times in that Fontanus reproduces the text of Sebastian's work with comments of his own and seems quite unaware that Sebastian Austrius had pirated the work of Roelans. There is a first edition of James Primrose's "Partes Duae de Morbis Puerorum" published in Rotterdam in 1659. Primrose is remembered chiefly today for his bitter opposition to the work of Harvey.

Still another treasure is "A general and compleat treatise on all the diseases incident to children . . . by the learned Dr. John Astruc." This is the English edition of Jean Astruc published in London in 1746, and it is interesting to note that there was no French edition of this title though it is believed that a manuscript at The Royal College of Physicians, London, is the original French source.

There is a copy of Cadogan's "Essay upon nursing, and the management of children," the second edition, published the same year as the first, 1748, and still signed simply "By a physician." Later editions bore the author's name. A reader who was using it in the library the other day said to the librarian, "You know, this is the earliest edition of this I have ever had in my hands!"

Part of the collection is on display in the library and we urge everyone to visit the library and see

this valuable contribution that Dr. Friedenwald has so generously made to the Faculty.

LIBRARY CHATTER

Dr. Harold Rosen, author of "Hypnotherapy in Clinical Psychiatry" and member of the Medical and Chirurgical Faculty, recently gave the library a copy of "Therapeutic Abortion." This book, published by Julian Press and edited by Dr. Rosen, covers all phases of the subject, medical, psychiatric, legal, anthropological and religious, and includes articles by other Faculty members, Drs. Manfred Guttmacher, Arthur J. Mandy, Harry Murdock and one ex-Faculty member, Dr. Alan Guttmacher. It should be of interest to general practitioners, psychiatrists, obstetricians and gynecologists.

Speaking of gynecologists, the February 1954 issue of "Obstetrical and Gynecological Survey" is a special issue in recognition of the seventieth birthday of Dr. Emil Novak. It was presented to him as a surprise on the occasion of a dinner given in his honor in Baltimore on March 4, 1954. Including as it does, biography, tributes, a bibliography and selections from his writings, we are sure a number of non-subscribers would like to see it. Borrow it from your library!

Dr. Henry J. L. Marriott, Associate Professor of Medicine at the University of Maryland and member of the Faculty, has also given us a copy of his new book, "Practical Electrocardiography." Modestly enough, he waited until we asked him for it. It is exactly what the title says, for it emphasizes the simplicities of the electrocardiogram, not the complexities. While it covers all the diagnostically important patterns, it does not bore you with unnecessary details.

We are happy to welcome to the Library staff Miss Miriam Carson, a graduate of the Girls Latin School, who later attended the Hawkins Business School and has had several years experience as receptionist and typist.

She will work chiefly with Mrs. Berge, helping with reclassifying and recataloging the book collection. She will also help with other phases of library work as needed.

Pediatricians will be particularly interested in a title recently added, "Behavior Disorders In Children" by Bakwin and Bakwin. The authors, a husband-and-wife team of pediatricians at New

York University, take the stand that the vast majority of childhood emotional disturbances can be handled adequately by the pediatrician or general practitioner and explain the natural forces that direct most children toward normalcy and mental health.

Another important title is the new edition of one of our most popular books, Lichtman's "Diseases of the Liver, Gallbladder and Bile Ducts." This new two-volume edition has all the features of the older

one but includes new advances in treatment of infectious hepatitis and portal cirrhosis, new amebicidal agents and antibiotics and a fully revised chapter on liver function tests.

A number of Faculty members are still unaware that parking space is available in the rear of the Faculty building until five o'clock. Enter from Maryland Avenue. Don't let lack of parking space on Cathedral Street keep you from using your library!

In Viewing the VA Medical Program . . .

*analysis
of present veteran population*

AGE DISTRIBUTION (Exclusive of those discharged on or after June 27, 1950)

DATE	JAN. 1, 1952	JAN. 1, 1960	JAN. 1, 1970
TOTAL	18,850,000	18,160,000	16,146,000
AGE 22-44	77.2%	62.7%	13.5%
45-64	21.8%	27.4%	73.7%
OVER 65	1.0%	9.9%	12.8%

Older veterans are hospitalized more frequently for civilian-incurred ailments than for service-connected disabilities. By 1970, over 86% of the present veterans will be age 45 or over, more than three times the number in this older age group today. Because of advanced age, they will require more frequent and prolonged hospitalization for illnesses having no relationship to their military service. Responsibility for such medical care should be assumed by the individual or local government, not by the federal government.

Health Departments

BALTIMORE CITY HEALTH DEPARTMENT

Housing Regulations Amended

On March 10 after very careful study the City Health Department adopted a major series of amendments to the "Rules and Regulations Governing the Hygiene of Housing" and the "Rules and Regulations Governing Rooming Houses, Lodging Houses and Hotels." The original regulations were first adopted by the Commissioner of Health on March 11, 1942.

The hygiene of housing has for many decades been a chief function of local health departments in some European countries. Its direct and preventive connection with the health of the people of a city like Baltimore has been obvious for many years.

Some considerable progress has been made during the past fifteen years in Baltimore in the control and correction of the city's worst slum areas. In this work among the chief health advances have been the elimination of nearly all the frost-proof yard hopper toilet nuisances, the removal of dilapidation on the premises, and an improvement in the rat control services of the city.

It is now the considered opinion of the City Health Department that the time has come for more positive action in the *prevention* of blight and slums, as equally important as a health measure as the *curative* nuisance abatement activity in this field during the past fifteen years. In this opinion, there is concurrence on the part of the Consultants, a group of the leading medical authorities in the city,

and on the part of the Health Department's Advisory Committee on Sanitation, the Advisory Council to the Housing Bureau, and many other official and nonofficial groups and agencies in Baltimore. In drafting the amended regulations Baltimore has had over many months the continued guidance of the special Housing staff of the U. S. Public Health Service and of Professor C.-E. A. Winslow of Yale University who is Chairman of the Committee on the Hygiene of Housing of the American Public Health Association and was Consultant on Housing to the Health Section of the League of Nations and more recently to the World Health Organization. As a result, the amended regulations have been adopted with the conviction that they are amply justified as public health measures designed for the protection of both the physical and the mental health of the inhabitants of the city.

In the opinion of the Commissioner of Health the point has now been reached when a carefully planned campaign must be put in operation to prevent the development of new blight or slums in Baltimore, and yet at the same time continue to correct and abate the existing slum conditions that remain within the city.

Copies of the above-mentioned amendments to the rules and regulations may be obtained by writing to the Baltimore City Health Department, Baltimore 3, Maryland.

Huntington Williams, M.D.

Commissioner of Health

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT
Case Reports Received during 4-week Period, February April 2-29, 1954

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARA- LYTIC	POLIOMYELITIS, NON- PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County.....	84	1	17	3	777	—	129	—	—	—	83	—	—	4	25	—	4	e-2	5
Anne Arundel.....	24	—	1	1	166	—	19	—	—	—	2	1	—	1	3	—	2	—	3
Howard.....	1	—	1	—	15	—	5	—	—	—	—	—	—	—	1	—	—	—	—
Harford.....	8	—	18	17	34	—	11	—	—	—	9	1	—	—	3	—	—	—	2
Carroll.....	1	—	—	2	43	—	2	—	—	—	20	—	—	—	1	—	—	—	1
Frederick.....	14	—	1	11	21	—	—	—	—	—	6	—	—	—	—	—	3	—	3
Washington.....	2	—	—	7	7	—	17	—	—	—	—	1	—	5	9	—	4	—	1
Allegany.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1
Garrett.....	—	—	—	5	—	—	2	—	—	—	4	—	—	—	—	—	1	—	2
Montgomery.....	39	—	3	8	124	2	61	—	—	—	10	—	—	—	4	—	1	p-1	1
Prince George's.....	19	—	8	2	135	—	24	—	—	—	31	—	—	1	4	—	1	a-2	2
Calvert.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Charles.....	3	—	—	—	2	—	2	—	—	—	—	—	—	—	2	—	—	c-1	—
Saint Mary's.....	4	1	—	3	85	—	7	—	—	—	3	—	—	—	—	—	—	—	—
Cecil.....	2	—	—	1	7	—	5	—	—	—	—	—	—	—	1	—	1	—	4
Kent.....	13	—	—	4	10	—	13	—	—	—	2	—	—	—	—	—	—	—	2
Queen Anne's.....	1	—	—	2	4	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Caroline.....	—	—	—	—	47	—	—	—	—	—	—	—	—	—	1	—	3	—	—
Talbot.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—
Dorchester.....	7	—	2	—	40	—	—	—	—	—	—	—	—	—	1	—	10	—	—
Wicomico.....	9	—	—	—	17	—	9	—	—	—	15	—	—	—	2	—	11	—	1
Worcester.....	2	—	—	—	39	—	—	—	—	—	—	—	—	—	3	—	—	—	—
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	6	—	1
Total Counties.....	233	2	51	66	1573	2	306	0	0	0	185	3	0	11	61	0	50		29
Baltimore City.....	282	0	18	1	1385	0	172	0	0	0	104	0	0	25	108	8	606		14
State																			
April 2—29, 1954.....	515	2	69	67	2958	2	478	0	0	0	289	3	0	36	169	8	656		43
Same period 1953.....	494	1	362	23	247	8	340	0	0	0	457	4	0	5	165	15	591		58
5-year median.....	559	2	239	—	740	5	250	2		1	149	2	3	30	240	40	493		62
Cumulative totals																			
State																			
Year 1954 to date.....	2352	6	165	394	8104	20	1768	3	0	0	942	4	1	290	717	64	2312		251
Same period 1953.....	2166	7	949	150	527	45	890	1	0	0	1574	8	2	72	798	55	2517		404
5-year median.....	2128	17	557	—	3005	28	796	8		1	639	7	12	164	905	175	2188		292

a = amoebiasis.
c = congenital syphilis under 1 year.
e = encephalitis, infectious.



Blue Cross - Blue Shield



REPORT FOR THE BOARD OF TRUSTEES OF MARYLAND MEDICAL SERVICE, INC.*

HUGH J. JEWETT, M.D., *President*

This is the fourth annual meeting of the Maryland Medical Service, and 1953 was its third full year of operation. It has been a year of steady and healthy growth, and our gains have been substantial. We as Trustees are now responsible for a very sizable operation, embracing over 220,000 persons in the community, with a growing annual income, approaching \$2,000,000 in 1953.

The year 1953 saw membership under our standard program increase by 33 per cent, from 84,738 to 112,475 at the year end. Widening interest in the program is evidenced by the increasing number of groups enrolled—now a total of 2,985, or 565 more than was reported at the end of 1952. More and more groups with Blue Cross coverage are adding Blue Shield, and nearly all new groups enrolled are now taking both coverages. The outlook is encouraging.

Our income in 1953 was \$1,703,764, and out of this we paid 82.2 per cent in benefits to subscribers. This percentage was slightly less than in the previous year, resulting in part from the adjustments in the fee schedule and subscription rates which were effected September 1, 1952. After all expenses, we were able to put 6.6 per cent of income aside for reserves, somewhat more than in 1952. Funds available for reserves have not been wholly adequate in the three years of the Plan's operation, and the small additional amount available for reserves in 1953 was most welcome.

Benefits were paid in 1953 to some 22,913 subscribers, or about one out of every ten enrolled, as compared with 18,633 subscribers in 1952. Under the standard program, 62 per cent of the cases involved surgery, 26 per cent were medical and the remaining 12 per cent obstetrical. The importance of in-hospital medical coverage, not available under many other Blue Shield Plans, is apparent from these figures.

* Given at the Annual Meeting of Maryland Medical Service, March 3, 1954.

The number of participating physicians also increased during the past year, to a new high of 1,736. This is concrete evidence of the increasing acceptance and support of the program by physicians throughout the State. Every doctor added to the list of participants increases the value of the Blue Shield program to the community.

Our biggest job ahead is a selling job. We are still a long way from our potential, having enrolled to date only 25 per cent of the total Blue Cross subscribers. It is not an easy job, and it is much more difficult than selling Blue Cross. Commercial competition in the area of surgical and medical coverage is much keener than in the field of hospitalization, and our late start in Maryland means that in most large groups we are faced with replacing an existing surgical and/or medical insurance. Also, with the *service* feature limited to subscribers with incomes under \$4,000, this is simply not as persuasive a selling factor as the service feature in Blue Cross. Under Blue Shield, it applies to about 50 per cent of the subscribers, while for the remainder the program simply helps to pay medical bills in much the same way as commercial coverage.

Sooner or later, a more realistic income provision must be established, and the fee schedule increased accordingly. Surgical care rendered in out-patient departments and in physicians' offices should be covered. But the Director believes, and I agree with him, that these and other improvements in the Plan should not be undertaken immediately, but should await some further growth in membership. During our first three years of operation we have had to make several important changes in fees and in rates; too frequent changes, although necessary, can be detrimental. Also, we need a little more time to strengthen our finances and our reserve position.

The special surgical program for Bethlehem Steel, under which we had 109,000 persons enrolled at the year end, will be re-negotiated in 1954, and I am informed that this program will be one of the first matters of business for the new Board of Trustees. The Director tells me that the proposed changes in this special program will very likely result in a considerable broadening of benefits during the next year.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. CHARLES H. WILLIAMS, *Auxiliary Editor*

MESSAGE FROM THE INCOMING PRESIDENT

MRS. ALBERT E. GOLDSTEIN*

The time has come after a year of training as President-elect for me to become your president.

No greater honor can you bestow upon an Auxiliary member.

It would be impossible for me to face my task lightly. I know the responsibility and hard work that lies ahead if I wish to attain the goal that your past presidents have reached.

It would discourage me if I thought I was expected to accomplish this year's work alone, but I know my Auxiliary. We have been associated together for five years. Some were lean years, but the greater the obstacle, the harder you worked.

Membership in our organization is unique. As members we are wives of physicians and as an Auxiliary we are organized to support our city, county and state medical societies and our American Medical Association. We need not operate alike but we aim to operate harmoniously.

Many wives of physicians are not trained health leaders. It is a responsibility acquired with a doctor husband.

Through self education we are taught to assist our county and state medical society in its program for the advancement of medicine and public health, "and to cultivate friendly relations and promote mutual understanding among physicians families."

On a basis of friendship and common interests, it has been possible to work effectively toward the carrying out of the other objectives of this organization.

Years ago broad minded men and women fought for the great cause of equal political and social rights

* Elected April 1954.



MRS. ALBERT E. GOLDSTEIN

for women. Today we have attained that result but last year's statistics proved that out of 50,000,000 eligible voters in the United States, forty per cent did not vote.

Equal rights mean equal responsibilities in all fields. An organization like ours is challenged to demonstrate this truth. Not only at the polls on election days, but in all health organizations where and when we are needed.

We aim to have good public relations with hospital Auxiliaries and civil defense projects in our state. Civil defense is definitely a part of national defense. Our job is to help people to help themselves. They want responsibility. Let us show them where it begins and what it means.

I hope the Auxiliary year 1954-55 will be for you as pleasant a memory as I know it will be for me.

PRESIDENT'S REPORT—1953-1954

MRS. JOHN G. BALL

The Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland feels that some real progress has been made in this, their fifth, year.

Organization and Membership: Letters were written to seventeen medical societies of unorganized counties by the Secretary of the Medical and Chirurgical Faculty. Four favorable replies were received, two not in favor; the remaining have not yet replied. One county, Wicomico, was organized; we are awaiting an invitation to visit three others. The overall membership in the state has been increased through the work of the individual county Auxiliaries. One county, Frederick, found it necessary to disband and become members-at-large. We hope in the near future they will again become active members. There has been a substantial increase in members-at-large which we feel is a very hopeful sign for further county organization.

Program: The Auxiliaries all meet at least four times a year. Two counties meet eight times. The most popular type of program is an outside speaker on an Auxiliary related subject. Three county Auxiliaries have distributed material at county fairs.

Nurse Recruitment: There are about twenty Future Nurses Clubs in the State. Some counties have had teas or hospital tours for interested high school girls and soon hope to have clubs organized. Baltimore County has published a Future Nurse Association News which we hope will be copied by other counties. Eight nursing scholarships have been awarded to capable girls who otherwise could not become nurses. Baltimore City Auxiliary has a Student Nurses Aid Fund to help girls already in training who may need financial help to finish their training. The Maryland nursing color sound film, "Girl With the Lamp," sponsored jointly by Maryland Society for Medical Research and Baltimore City Auxiliary, was shown at the Chicago Conference of Presidents and President-Elects and enthusiastically received. There have been many requests from other states, as well as our own state, for bookings. Our biggest state Nurse Recruitment project is our Future Nurses Convention. It will be held in Towson High

School, Saturday, May 1st. We have invited speakers in the various fields of nursing and student nurses in uniform to come. All junior and senior high school girls in the state have been invited to attend.

Doctor's Day: On February 7th, the Governor issued a proclamation designating March 30th as "Doctor's Day" in Maryland. Our State Chairman had an engraved plate and mats made so that all the newspapers in the state published the proclamation. Each organized county has celebrated Doctor's Day by pinning a red carnation on the doctors in the county or having a luncheon or dinner-dance. A memorial for deceased doctors was placed in many hospitals.

Civil Defense: Each Auxiliary has had a speaker or film on Civil Defense. Four counties have had home nursing courses. Your President spoke on the Civil Defense panel on Training of Personnel for Civil Defense at the Chicago Conference.

Legislation: Two big issues have been worked on this year; the Bricker Amendment and Veterans Medical Care Program. The Legislation Chairman has contacted all Auxiliaries and sent them pertinent information on these subjects. Your President attended two meetings in Washington on behalf of the Bricker Amendment, at the request of the Medical and Chirurgical Faculty.

American Medical Education Foundation: Three counties have contributed to the Foundation; one memorial was given by the state. All the members have been informed of the necessity of continued support of the Foundation.

Publications: Subscriptions for the "Bulletin" and "Today's Health" have been taken in all counties. The Auxiliary has had worthwhile reading material in each issue of the Maryland State Medical Journal. Newspapers throughout the state have cooperated in carrying Auxiliary news items. Our Future Nurses Convention has been written up in two national publications.

State Meetings: Montgomery County Auxiliary assisted with arrangements for the Semi-Annual meeting in Bethesda. Baltimore City again planned a most successful and entertaining Med-Chi Ball the first day of the annual meeting in Baltimore.

Invitations and Travels: Your President has visited the six organized counties of the state. In addition you were represented at the National

Auxiliary Convention, New York, June 1-5; Delaware State Convention, Oct. 13th; Chicago Conference, Nov. 18-19; Pennsylvania Conference, Harrisburg, March 16th. Other Board members have represented the Auxiliary at the Maryland State Nurses Association and Maryland League for Nursing and the Maryland State Hospital Auxiliary meeting.

President's Pin: A pin has been designed and made for the State President to wear to all her various state and national meetings. It is hoped that, budget permitting, all past presidents will eventually have similar pins.

Addressograph: All the organized counties home addresses were checked, corrected and new plates

made where necessary. We hope all members are now getting their mail at their homes. The Medical and Chirurgical Faculty paid for additional plates needed. In the new roster of the Medical and Chirurgical Faculty a mark has been placed beside the name of each doctor whose wife is an Auxiliary member.

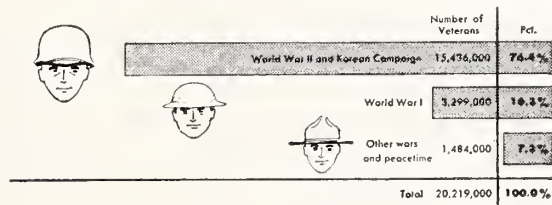
This has been a worthwhile year in Auxiliary work. Any progress we have made has been because we were all working *together*. Maryland has really lived the Auxiliary theme for the year, "Together We Progress."

Respectfully submitted,
Monica S. Ball (Mrs. John G.)
President

In Viewing the VA Medical Program . . .

analysis of veteran population

PERIOD OF SERVICE



Taxpayers should note that as veterans grow older they require more frequent and increasingly longer periods of hospitalization. World War I patients are now hospitalized twice as long, on the average, as World War II patients with similar disabilities. World War II veterans, relatively young and comprising 76% of the total veteran population, present a costly long term responsibility to U. S. taxpayers. The medical profession recommends medical care through the VA for only those veterans with service-incurred disabilities and temporarily for those with tuberculosis or neuropsychiatric conditions of non-service-connected origin.

ARTICLES OF INTEREST

SETON INSTITUTE OF BALTIMORE

JAMES S. WHEDBEE, JR., M.D.¹

The Seton Institute of Baltimore, Maryland, has announced the appointment of Dr. Leo H. Bartheimer as Medical Director. He will assume his duties in October 1954, succeeding Dr. Walter O. Jahrreiss who has been Medical Director since 1951.

The Seton Institute is the oldest Catholic mental hospital in the country, being owned and administered by the Daughters of Charity of St. Vincent de Paul. Their tradition of nursing the mentally ill goes back to their founder St. Vincent de Paul who cared for several "insane" committed by their relatives at St. Lazare in Paris during the seventeenth century.

In this country the Daughters of Charity opened their first institution with eighteen patients in Baltimore in 1840 under the medical direction of Doctor Durkee. After three succeeding moves necessitated by the rapidly increasing number of patients applying for care, the Sisters in 1860, constructed part of a new institution called Mount Hope Retreat at the present site of The Seton Institute. By 1867, Dr. William H. Stokes, then medical director, in the 25th Annual Report, noted that the hospital for that year numbered 200 patients and that, in the past, 4,898 patients from many states of the Union had been treated at the institution.

By an act of the General Assembly of Maryland, 1870, Mount Hope Retreat was incorporated and chartered as an institution of public service, owned by the Daughters of Charity. From the beginning male as well as female patients had received nursing care exclusively from the Sisters of Charity, and it was the continued policy to have each hall cared for by two Sisters throughout the 24 hours. It is also interesting that having served in 1841 under Dr. Conolly, Superintendent and Physician of Hanwell, London, who in 1839 first advocated the abolition of mechanical restraint, Dr. Stokes, upon his appointment to the then Mt. St. Vincent's Hospital in 1842, changed the time-honored principles of

treatment of Cullen and Rush and, maintaining the principle of non-restraint and relied on personal nursing care, "hygienic measures, proper nutrition, exercise and suitable occupation." (It is believed that Dr. Stokes was one of the founders of the Association of Medical Superintendents of American Institutions for the Insane, which first met in Philadelphia in 1844, and which later became the American Medico-Psychological Association, and presently the American Psychiatric Association.) By 1900 the patient population was about 600.

Prior to 1925 all nursing care was rendered exclusively by the Sisters. Lay nurses were then included, and the School of Nursing, begun informally in the 1880's, was officially organized and approved by the Maryland State Board of Examiners of Nurses in 1929, receiving at that time affiliate students from eighteen schools. The School of Nursing currently offers a three months course to over 600 affiliate students from 20 schools annually.

In 1945 a major reorganization was undertaken to change Mount Hope Retreat from an institution of custodial care to an active treatment and clinical training center. Its name was changed to The Seton Institute and a Medical Advisory Board was appointed. At that time the Advisory Board was composed of Dr. Wendell Muncie, Chairman; Dr. Horace Richardson, Secretary; Dr. Lewis B. Hill; Dr. Arthur J. Lomas; Dr. Ralph Truitt; and Dr. Esther Richards. The unusual feature of the new plan was the creation of an active visiting staff similar to such staffs in general hospitals, such psychiatrists to have the privilege of admitting their private patients to The Seton Institute and of treating them personally according to the privileges and advantages enjoyed by the general practitioner, internist and surgeon in general hospitals. In line with the establishment of an acute service, many chronic patients were transferred to the State Hospitals and the bed capacity of the institution was reduced to about 335 of which 162 beds are for acute patients and 173 for chronic patients.

In 1952 a new constitution and by-laws were drawn up in which the intramural governing of the

¹ Secretary, Executive Coordinating Board.

hospital was invested in an Executive Coordinating Board on which all major disciplines are represented. In addition to the resident staff, there is a visiting staff of 32 members. The Institute is presently accredited by the American Board of Psychiatry and Neurology for a two-year residency.

MRS. HOBBY URGES FAVORABLE ACTION ON NEW HEALTH GRANT BILL

THE AMA Washington Letter, No. 61

Mrs. Oveta Culp Hobby, Secretary of Health, Education, and Welfare, urged the House Interstate and Foreign Commerce Committee on March 4, to approve the administration's bill (H.R. 7397) which eliminates Public Health Service categorical grants and sets up three new groups of state grants. The measure, she said, represents a concerted effort to simplify and improve the administration of 14 major grant-in-aid programs of HEW. She added the bill also would (1) provide states with a more flexible means of meeting changing health needs, and (2) clearly define and identify objectives of federal grants and enable Congressional funds to be directly related to these objectives.

AMA SUPPORTS GRANT BILL, BUT SUGGESTS SOME CHANGES

The AMA Washington Letter, No. 62

American Medical Association has approved the administration bill doing away with numerous categorical health grants and setting up three broad groups for grants to states. Dr. George F. Lull, secretary and general manager, wrote the House Interstate and Foreign Commerce Committee that the AMA "which has always promoted state and local health services . . . approves the bill generally," although it has reservations on some provisions and believes clarification is imperative.

The bill (H.R. 7397) provides three types of grants: Type 1 grants to help states meet costs of public health services; type 2 grants to aid states in initiating projects for extension and improvement of services; and type 3 grants which would assist states as well as public and other non-profit groups to launch special projects of regional or national significance.

The AMA proposed that types 1 and 2 grants be lumped into one category, thereby placing initial responsibility for extension and improvement of health services in the hands of the state health officer. Other suggestions were (1) in view of "apparently unlimited authority" given the surgeon general of Public Health Service in type 3 grants, language in the act should be clarified to require the surgeon general to consult with state health authorities before making such grants, and (2) the bill should spell out percentages of total funds to be used in each category, with amounts for special "type 3" projects held to a small percentage.

Dr. Lull called attention to the work of the Commission on Intergovernmental Relations which is inquiring into grants-in-aid to states. It might be desirable, he said, to have "the benefits of its findings and recommendations in this highly important field prior to extensive legislation changing the present grant-in-aid policies and requirements."

The House committee heard administration witnesses in support of the measure in a one-day hearing, and a week later received testimony from spokesmen of the Association of State and Territorial Health Officers. Secretary Hobby of the Department of Health, Education, and Welfare said the bill would give the states greater freedom in the allocation of funds.

COMING MEETINGS

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty.

Richard W. TeLinde, M.D., *Chairman*

Beverley C. Compton, M.D., *Secretary*

1211 Cathedral Street, Baltimore

Thursday, June 17, 1954, 5:00 to 6:00 p.m.

WORK CONFERENCE

TUBERCULOSIS NURSING

May 24, 25, 26, 27, 28, 1954

Sponsored by: The Maryland League for Nursing, The Maryland State Nurses Association and the Maryland Tuberculosis Association.

Theme: Changes in patient care and tuberculosis control.

Place: Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland

Registration fee: None

This five day conference is open for full-time participation to all graduate and student nurses, practical nurses and hospital attendants. Physicians, social workers, occupational therapists, rehabilitation workers and all others interested in the care of tuberculosis patients are invited to attend the general sessions.

General Program: Tuberculosis in Maryland—past and present.

Nature of tuberculosis

Advances in medical and surgical treatment.

Changes in home and clinic care

Special services for tuberculosis patients

Visits to new tuberculosis hospitals in or near Baltimore

Viewing a new motion picture film on tuberculosis

Group topics: Teaching tuberculosis in schools of nursing (others as requested)

Eating facilities: Meals are available for 50 cents each in the cafeteria of the Baltimore City Hospitals. Tickets are obtainable at the information desk in the general hospital.

Rooms: Rooms for those who cannot commute are available at the rate of \$2.00 per night in the Nurses' Residence, Baltimore City Hospitals

Parking: Ample space on hospital grounds.

A.M.A. NEWS RELEASE—WASHINGTON OFFICE

Washington, D. C.—These spring days are growing into weeks that really count in Congress. Unless a bill deals with an emergency, it had better be well on its way through committees by now or its chances of enactment will fade rapidly as summer approaches.

For good or evil, a large amount of health legislation is well advanced, and if Congress holds to an average pace several bills affecting the medical profession are likely to become law in the next month or so. Here is the situation in brief:

Medical Deductions. Legislation to increase the amount deducted from taxable income for medical expenses is a part of the omnibus tax revision bill which cleared the House early and by a wide margin, but ran into some delay on the Senate side. This bill, with the medical deduction liberalization intact, should reach the White House in plenty of time.

Hill-Burton Expansion. A move to make important changes in this bill developed in the Senate Labor and Welfare Committee, after the House had passed its version with some amendments. American Hospital Association proposed that the rather complicated House legislation be scrapped, and instead that the Hill-Burton Act be amended to (a) include rehabilitation centers and nursing homes, and (b) place a high priority on hospitals for the chronically ill. The AHA idea immediately attracted support in and out of the committee. The new approach suggested by AHA meant inevitable, but probably not fatal, delays.

Reinsurance. This proposal, once hailed as the keystone of the Eisenhower administration's health program, continued to encounter opposition. At one stage, of all the national associations to testify on reinsurance only American Hospital Association was giving it unqualified support. American Medical Association, the U.S. Chamber of Commerce, and national spokesmen for the insurance industry took about the same position: 1. Reinsurance alone cannot make uninsurable risks insurable. 2. The threat of federal control of medicine is inherent in any program that would bring the federal government in such close contact with medical practice. Dr. David B. Allman, representing the AMA at the House hearings, emphasized that the Association would welcome and cooperate in any movement carrying real promise of promoting voluntary health insurance.

Health Grants. This is an administration plan to do away with the present categorical grants for identified projects, such as venereal disease control, and to substitute funds earmarked for three general purposes, (a) to maintain present programs, (b) to initiate new programs or to expand existing ones, and (c) to finance public or private experimental or pilot programs of national or regional significance. In both committees the question was whether to group the first and second type grants together, with the state health authorities deciding how to divide up the federal money among old and new projects. Funds for the third type grant—experimental—would be completely controlled by the surgeon general. One suggestion is to require approval of the state health officer for any experimental (type three) grant in his state. Another is to eliminate the third type grants altogether, letting the National Institutes of Health handle public health as well as other medical research grants.

Social Security. American Medical Association, American Dental Association and a number of other national groups are fighting vigorously to prevent compulsory extension of Old Age and Survivors Insurance to physicians, dentists and most other self-employed. Instead, they want the privilege of deferring income tax payments on that part of earnings placed in restricted annuities—the Jenkins-Keogh plan. AMA also feels that there is no need for the bill's provision that pension rights be frozen during periods when the worker has been medically determined to be disabled. A better suggestion, the Association maintains, is to base pension rates on the ten best working years, thus virtually eliminating the need for the contro-

versial medical examinations. Prospects are good that social security will be extended, either with or without these changes.

Vocational Rehabilitation. Generally, Senate witnesses favor the administration's proposal to expand the federal-state programs, providing U.S. grants aren't cut. However, with no House bill introduced as of this writing, there is some doubt that, even if the Senate clears the measure, the House can find time to deal with it.

Doctor Draft Amendment. This bill, an outgrowth of the Peress case, swept through the Senate without objection. It may be law by the time this is published. It would amend the Doctor Draft act to permit the services to keep on duty as an enlisted man, assigned to professional tasks, anyone called under the Doctor Draft act whose loyalty is questioned. Defense Department has promised to investigate such cases immediately, so that the man can be cleared promptly and offered a commission or discharged. The discharge would state that action was taken on loyalty grounds.

FEDERAL OFFICIALS GATHER DATA FOR U.S. EMPLOYEE HEALTH PLAN

The AMA Washington Letter, No. 61

A fact-finding committee of federal officials is scheduled to start an inquiry next week on private voluntary health plans. It will confer with industry, Blue Cross and Blue Shield Commissions, unions and others. Later the committee will draft legislation to carry out President Eisenhower's proposal for a contributory program of health insurance for federal workers. The committee is made up of officials from the Department of Health, Education, and Welfare, Treasury Department, Budget Bureau, General Accounting Office, and Civil Service Commission. Should Congress vote a program, it is expected that Civil Service, the top personnel agency for government, will have the job of administering it. The fact-finding study is being supervised by Warren B. Irons, chief of CSC's Bureau of Departmental Operations.

The proposal, first made by the President as part of a 9-point legislative program for federal employees, calls for the government paying up to \$26 a year for each employee's insurance premiums, with the latter matching an equal amount. If his premiums exceed \$52 a year, he would be expected to pay the added amount. It is proposed that coverage be available to both employee and his family, with the option of selecting hospital, medical or surgical benefits, or all three. The insurance would be written by commercial companies and non-profit associations. The program also contemplates a federal contribution each year of \$50 million.

DIRECTORY*

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

March 31, 1953—March 31, 1954

LIST OF PRESIDENTS—1799—1954

- | | | |
|---|--|---|
| <p>1799—1801—Upton Scott.
 1801—1815—Philip Thomas.
 1815—1820—Ennals Martin.
 1820—1826—Robert Moore.
 1826—1836—Robert Goldsborough.
 1836—1841—Maxwell McDowell.
 1841—1848—Joel Hopkins.
 1848—1849—Richard Sprigg Steuart.
 1849—1850—Peregrine Wroth.
 1850—1851—Richard Sprigg Steuart.
 1851—1852—William W. Handy.
 1852—1853—Michael S. Baer.
 1853—1854—John L. Yeates.
 1854—1855—John Fonerden.
 1855—1856—Jacob S. Baer.
 1856—1857—Christopher C. Cox.
 1857—1858—Joshua I. Cohen.
 1858—1859—Joel Hopkins.
 1859—1870—Geo. C. M. Roberts.
 1870—John R. W. Dunbar.
 1870—1872—Nathan R. Smith.
 1872—1873—P. C. Williams.
 1873—1874—Charles H. Ohr.
 1874—1875—Henry M. Wilson.
 1875—1876—John F. Monmonier.
 1876—1877—Christopher Johnston.
 1877—1878—Abram B. Arnold.
 1878—1879—Samuel P. Smith.
 1879—1880—Samuel C. Chew.
 1880—1881—H. P. C. Wilson.
 1881—1882—Frank Donaldson.
 1882—1883—William M. Kemp.
 1883—1884—Richard McSherry.
 1884—1885—Thomas S. Latimer.
 1885—1886—John R. Quinan.
 1886—1887—George W. Miltenberger.</p> | <p>1887—1888—I. Edmondson Atkinson.
 1888—1889—John Morris.
 1889—1890—Aaron Friedenwald.
 1890—1891—Thomas A. Ashby.
 1891—1892—William H. Welch.
 1892—1893—L. McLane Tiffany.
 1893—1894—George H. Rohé.
 1894—1895—Robert W. Johnson.
 1895—J. Edwin Michael.
 1895—1896—Charles G. Hill.
 1896—1897—William Osler.
 1897—1898—Charles M. Ellis.
 1898—1899—Samuel C. Chew.
 1899—1900—Clotworthy Birnie.
 1900—1901—Samuel Theobald.
 1901—1902—J. McPherson Scott.
 1902—1903—William T. Howard.
 1903—1904—Eugene F. Cordell.
 1904—1905—Edward N. Brush.
 1905—1906—Samuel T. Earle, Jr.
 1906—1907—Hiram Woods.
 1907—1908—Charles O'Donovan.
 1908—1909—Brice W. Goldsborough.
 1909—1910—G. Milton Linthicum.
 1910—1911—Franklin B. Smith.
 1912—Hugh H. Young.
 1913—Archibald C. Harrison.
 1914—Randolph Winslow.
 1915—J. W. Humrichouse.
 1916—J. Whitridge Williams.
 1917—Guy Steele.
 1918—William S. Halsted.
 1919—John Ruhrah.
 1920—James E. Deets.
 1921—William S. Gardner.
 1922—Arthur H. Hawkins.</p> | <p>1923—Herbert Harlan (Jan.—Aug).
 Harry Friedenwald (Aug.—Dec.).
 1924—Philip Briscoe.
 1925—Lewellys F. Barker.
 1926—Thomas B. Johnson, Deceased
 December 25, 1925.
 1926—Josiah S. Bowen.
 1927—Thomas S. Cullen.
 1928—Peregrine Wroth, Jr.
 1929—Alexius McGlannan.
 1930—Henry M. Fitzhugh.
 1931—J. M. H. Rowland.
 1932—Eldridge E. Wolff.
 1933—J. Albert Chatard.
 1934—George O. Sharrett.
 1935—J. M. T. Finney, Sr.
 1936—Frederick D. Chappellear.
 1937—Arthur M. Shipley.
 1938—Frank B. Hines.
 1939—Dean Lewis: Acting President,
 Victor F. Cullen.
 1940—Edward P. Thomas.
 1941—Harvey B. Stone.
 1942—R. Lee Hall.
 1943—Charles R. Austrian.
 1944—Jacob W. Bird.
 1945—Carroll Lockard.
 1946—Thomas R. Chambers.
 1947—William T. Hammond.
 1948—Charles W. Maxson.
 1949—W. Houston Toulson.
 1950—A. Austin Pearre.
 1951—Walter Dent Wise.
 1952—Alan M. Chesney.
 1953—Maurice C. Pincoffs.
 1954—Bender B. Kneisley.</p> |
|---|--|---|

LIST OF VICE-PRESIDENTS

- | | | |
|---|--|--|
| <p>1799—1848—(Unknown.)
 1848—1849—John Readell, Jacob Baer,
 P. Wroth.
 1850—1851—Joel Hopkins, P. Wroth,
 Jacob Fisher.
 1851—1853—(Unknown.)
 1853—1854—John Fonerden, Albert
 Ritchie, P. Wroth.
 1854—1855—Geo. C. M. Roberts,
 Samuel P. Smith, Joel Hopkins.</p> | <p>1855—1856—George C. M. Roberts,
 G. W. Miltenberger, M. Diffe-
 derffer.
 1856—1857—P. Wroth, Wm. H.
 Davis, Samuel Smith.
 1857—1858—William Waters, Fred-
 erick Dorsey, Joel Hopkins.
 1858—1859—Samuel Chew, Stephen
 N. C. White, Samuel K. Handy.</p> | <p>1859—1863—John R. W. Dunbar,
 Samuel Chew, Wm. M. Kemp.
 1863—1871—John R. W. Dunbar,
 Wm. M. Kemp, John C. Hopkins.
 1871—1872—C. H. Ohr, Edward
 Warren, Richard McSherry.
 1872—1873—(Unknown.)
 1873—1874—Samuel Chew, H. M.
 Wilson, A. B. Arnold.</p> |
|---|--|--|

* Transactions, 1954.

- 1874-1875—Francis T. Miles, James A. Steuart, D. A. O'Donnell.
- 1875-1876—Christopher Johnston, A. B. Arnold, J. C. Thomas.
- 1876-1877—P. C. Williams, James A. Steuart, Francis T. Miles.
- 1877-1878—S. C. Chew, F. E. Chatard, Charles H. Jones.
- 1878-1879—James C. Thomas, L. McLane Tiffany.
- 1879-1880—H. P. C. Wilson, James A. Steuart.
- 1880-1881—L. McLane Tiffany, G. Ellis Porter.
- 1881-1882—A. H. Bayly, I. E. Atkinson.
- 1882-1883—Thomas S. Latimer, Richard McSherry.
- 1883-1884—W. Stump Forward, J. S. Lynch.
- 1884-1885—John R. Quinan, I. E. Atkinson.
- 1885-1886—E. C. Baldwin, J. E. Michael.
- 1886-1887—Thomas Opie, Richard Gundry.
- 1887-1888—Charles H. Jones, James Carey Thomas.
- 1888-1889—J. E. Michael, Thomas P. Evans.
- 1889-1890—T. A. Ashby, C. G. W. Macgill.
- 1890-1891—Geo. H. Rohé, J. McPherson Scott.
- 1891-1892—J. W. Humrichouse, David Streett.
- 1892-1893—J. W. Downey, J. W. Chambers.
- 1893-1894—John D. Blake, John S. Fulton.
- 1894-1895—Charles H. Jones, W. M. Nihiser.
- 1895-1896—Charles G. Hill, Clotworthy Birnie.
- 1896-1897—Wilmer Brinton, Randolph Winslow.
- 1897-1898—W. F. A. Kemp, George J. Preston.
- 1898-1899—Mary Sherwood, J. McPherson Scott.
- 1899-1900—Samuel Theobald, David Streett.
- 1900-1901—Samuel T. Earle, Jr., J. B. R. Purnell.
- 1901-1902—Harry Friedenwald, B. W. Goldsborough.
- 1902-1903—Samuel T. Earle, Jr., Wilmer Brinton.
- 1903-1904—Franklin B. Smith, James M. Craighill.
- 1904-1905—Samuel T. Earle, Jr., D. C. R. Miller, Julius A. Johnson.
- 1905-1906—Charles O'Donovan, Thomas M. Chaney, Joseph B. Seth.
- 1906-1907—William T. Watson, Philip Briscoe, William F. Hines.
- 1907-1908—Roger Brooke, Henry L. P. Naylor, George Dobbin.
- 1908-1909—Philip Briscoe, William L. Smith, G. Milton Linthicum.
- 1909-1910—Philip Briscoe, A. P. Herring, Compton Riely.
- 1910-1911—J. Staige Davis, H. B. Gantt, Timothy Griffith.
- 1912—J. L. Riley, D. E. Stone, J. A. Chatard.
- 1913—J. Staige Davis, C. F. Davison, E. B. Claybrook.
- 1914—C. R. Winterson, A. L. Franklin, Gordon Wilson.
- 1915—A. McGlannan, J. E. Deets, R. Lee Hall.
- 1916—L. C. Carrico, M. D. Norris, J. A. Chatard.
- 1917—D. E. Stone, A. H. Hawkins, J. M. H. Rowland.
- 1918—Julius Friedenwald, J. E. Deets, J. McF. Dick.
- 1919—J. McF. Bergland, Philip Briscoe, J. E. Deets.
- 1920—T. R. Boggs, A. M. Shipley, Eugene Jones.
- 1921—J. H. M. Knox, Jr., A. H. Hawkins, C. E. Davidson.
- 1922—Harry Friedenwald, W. R. White, J. S. Bowen.
- 1923—J. M. H. Rowland, Harry Friedenwald, Peregrine Wroth, Jr.
- 1924—C. Urban Smith, J. Percy Wade, E. E. Wolff.
- 1925—J. S. Bowen, T. B. Johnson, J. McF. Dick.
- 1926—Standish McCleary, G. Roger Myers, S. A. Nichols.
- 1927—Standish McCleary, John L. Riley, Frank S. Keating.
- 1928—J. Albert Chatard, F. B. Hines, R. T. Miller, Jr.
- 1929—Henry M. Fitzhugh, Robert P. Bay, Thomas R. Boggs.
- 1930—F. D. Chappleear, W. T. Hammond, F. B. Hines.
- 1931—W. D. Campbell, H. M. Lankford, Charles Maxson.
- 1932—W. T. Hammond, John T. King, Jr., Lewis K. Woodward.
- 1933—S. A. Nichols, E. H. Hutchins, W. S. Seymour.
- 1934—G. C. Lockard, W. R. White, J. L. Riley.
- 1935—J. McF. Dick, Louis Hamman, V. D. Miller.
- 1936—Harvey G. Beck, Norman S. Dudley, Jesse O. Purvis.
- 1937—Harvey B. Stone, W. A. Gracie, R. Lee Hall.
- 1938—Frank S. Lynn, Richard C. Dodson, Everard Briscoe.
- 1939—Victor F. Cullen, Frederic V. Beitler, William D. Noble.
- 1940—Edward P. Smith, H. A. Cantwell, Charles L. Owens.
- 1941—Guy L. Hunner, Charles R. Foutz, R. Lee Hall.
- 1942—Maurice C. Pincoffs, Wm. F. Williams, Jacob W. Bird.
- 1943—Charles Reid Edwards, A. Austin Pearre, J. Oliver Purvis.
- 1944—Alan M. Chesney, William D. Campbell, Hugh R. Spencer.
- 1945—William N. Palmer, Harry R. Slack, Armfield F. Van Bibber.
- 1946—William D. Noble, Grant E. Ward, John S. Green, Jr.
- 1947—Huntington Williams, Frank M. Wilson, J. Herbert Bates.
- 1948—William Neill, Jr., Baltimore; Samuel E. Enfield, Cumberland; F. Seton Waesche, Snow Hill.
- 1949—Amos R. Koontz, Baltimore; O. H. Binkley, Hagerstown; P. E. Cox, Easton.
- 1950—I. Ridgeway Trimble, Baltimore; Vincent H. Davis, Chesapeake City; Thomas K. Galvin, Baltimore.
- 1951—Samuel McLanahan, Baltimore; Frank D. Worthington, Frederick; Frank W. Smith, Chestertown.
- 1952—Frank J. Geraghty, Baltimore; W. A. Gracie, Cumberland; Deceased 12-28-51; William F. Williams, Cumberland; R. Carmichael Tilghman, Baltimore.
- 1953—George O. Eaton, Baltimore; Osborne D. Christensen, Salisbury; William F. Williams, Cumberland.
- 1954—E. Paul Knotts, Denton; Ernest I. Cornbrooks, Jr., Baltimore; Ralph G. Hills, Baltimore.

ACTIVE MEMBERS OF COMPONENT SOCIETIES, 1954*

Allegany-Garrett County

Alvarez, Joseph, 101 3rd Street, Oakland, Md.
 Ballin, R. W., 62 Greene Street, Cumberland, Md.
 §Baumgartner, E. I., Oakland, Md.
 Benjamin, Gilbert W., Hillen Station-Western Md. R.R. Co., Baltimore 2, Md.
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 Cowherd, J. Kile, 41 Greene Street, Cumberland, Md.
 §Daugherty, Leslie E., 7 Washington Street, Cumberland, Md.
 Davis, Frank U., 22 Washington Street, Cumberland, Md.
 Davis, John B., 2 Broadway, Frostburg, Md.
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 Devers, John C., Frostburg, Md.
 Diehl, H. C., Frostburg, Md.
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 Owens, Charles L., 305 Washington Street, Cumberland, Md.
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 Rothstein, Martin M., Frostburg, Md.

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 §Trevaskis, R. W., Jr., 220 Baltimore Ave., Cumberland, Md.
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 Weisman, Saville G., 59 Greene Street, Cumberland, Md.
 Wenzel, J. W., Oak & 8th Streets, Oakland, Md.
 Whitworth, Fuller B., 123 Bedford Street, Cumberland, Md.
 Williams, Richard Jones, 122 South Centre Street, Cumberland, Md.
 Williams, William F., 122 South Centre Street, Cumberland, Md.
 Wolferman, Adolf, 5505 Groveland Ave., Baltimore 15, Md.
 Zimmerman, Charles Conrad, 105 South Centre Street, Cumberland, Md.

Anne Arundel County

Alexander, John G., Crain Highway & 2nd Ave., Glen Burnie, Md.
 Allen, Aris Tee, 10 Carroll Street, Annapolis, Md.
 Allen, Faye W., 10 Carroll Street, Annapolis, Md.
 Anderson, Albert L., 44 Southgate Ave., Annapolis, Md.
 | Armstrong, Robert H., Jr., 71 Franklin Street, Annapolis, Md.
 Ball, Charles L., Jr., 203 W. Maple Road, Linthicum Heights, Md.
 Basil, George C., 59 Franklin Street, Annapolis, Md.
 Beard, J. Howard, 626 P. O. Box, Annapolis, Md.
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 Bene lict, Ludwig, Crownsville, Md.

* Unless otherwise designated.

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- Borssuck, Samuel, Amos Garrett Blvd., Annapolis, Md.
- Briscoe, Philip, 95 Cathedral St., Annapolis, Maryland
- Christhilf, Stuart Jr., 69 Franklin Street, Annapolis, Md.
- Clark, John A., House of Correction, Jessups, Md.
- Codd, Francis I., Severna Park, Md.
- Eichert, Arnold H., Crownsville State Hospital, Crownsville P.O., Md.
- Faubert, Gustav H., 5 First Ave., S. E., Glen Burnie, Md.
- Field, Edward G., 1 Crain Highway, Glen Burnie, Md.
- French, William J., 116 Gloucester Street, Annapolis, Md.
- §Gaalaas, A. F., 10815 53rd. Ave. North, St. Petersburg, Fla.
- Gould, Vincent, Mayo, Md.
- Grant, Bowie Linn, Shadyside, Md.
- Grimaldi, Pasquale John, 4609 Gov. Richie Highway, Baltimore 25, Md.
- Hadley, Henry G., 1252 6th Street S. W., Washington 4, D. C.
- Hooker, Donald, 90 Cathedral Street, Annapolis, Md.
- Hunt, Barbara, Ewell, Md.
- Johnson, Theodore H., 40 Northwest Street, Annapolis, Md.
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- Klawans, Maurice F., 31 Southgate Ave., Annapolis, Md.
- Klinger, Stephen, Crownsville State Hospital, Crownsville, Md.
- Linhardt, Elmer G., 3 Chesapeake Ave., Eastport, Md.
- Linthicum, Charles, 106 W. Maple Road, Linthicum Heights, Md.
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- Manuzak, Hubert F., 901 Edgerly Road, Harundale, Glen Burnie, Md.
- Martin, James R., 185 Prince George Street, Annapolis, Md.
- Morgenstern, Jacob, Crownsville State Hospital, Crownsville, Md.
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- Purvis, Jesse Oliver, 40 Franklin Street, Annapolis, Md.
- Richardson, R. L., 110 Clay Street, Annapolis, Md.
- Ritchings, E. Peyton, Victor Cullen Hospital, State Sanitorium, Md.
- Rodler, Edith, 45 Franklin Street, Annapolis, Md.
- Russell, John T., 113 Chesapeake Ave., Eastport, Md.
- Sheehan, Joseph Chester, 69 Franklin St., Annapolis, Md.
- Shipley, Frank M., 63 College Ave., Annapolis, Md.
- Sims, Neil H., 184 Gloucester St., Annapolis, Md.
- Skerritt, Edward G., Millersville, Md.
- Sosnowski, A. R., 4016 Ritchie Highway, Baltimore 25, Md.
- Thomas, William Nathaniel Jr., 71 Franklin Street, Annapolis, Md.
- Trettin, G. Douglas, Severna Park, Md.
- Trevett, Elizabeth Peabody, % American Embassy, Bagdad, Iraq
- Waite, Merton T., 56 Southgate Ave., Annapolis, Md.
- Walker, Stuart H., Carvel Hall, Annapolis, Md.
- Weitzman, F. E., 130 Lafayette Ave., Annapolis, Md.
- Welch, Robert S. G., 86 State Circle, Annapolis, Md.
- Wilkins, Jesse Lee, 232 Prince George Street, Annapolis, Md.
- *Willoughby, M. K., Ritchie Highway at Sand Rock Building, Severna Park, Md.
- Wilson, Emily H., Harwood, Md.
- Wright, J. Le Roy, Cockeysville, Md.
- Zangara, H. F., 307 Newburg Ave., Baltimore 28, Md.
- Baltimore City*
- Active Members*
- Abbott, Thomas G., 4509 Liberty Heights Avenue—7
- Abercrombie, Anna S., College Manor, Lutherville, Md.
- Abercrombie, Ronald T., 3908 N. Charles Street—18
- §Abeshouse, Benjamin S., 100 W. Monument Street—1
- Abraham, Robert Auman, 1712 Aberdeen Road—4
- Abramovitz, Leonard J., 2519 Talbot Road—16
- Abrams, Michael A., 1820 Eutaw Place—17
- Abrams, Robert Calvin, 1820 Eutaw Place—17
- §Acton, Conrad, 1208 St. Paul Street—2
- Acton, Elizabeth, 700 Cathedral Street—1
- Adams, Frederick K., 1222 N. Caroline Street—13
- Adams, Maurice L., 238 N. Carey Street—23
- Adams, Nicholas Floyd, 'Jr., 1118 St. Paul Street—2
- §Adams, Thurston R., University Hospital—1
- Akman, Leonard Carl, 803 Cathedral Street—1
- Alagia, Damian P., 305 Frederick Avenue—28
- Alecce, A. Andrew, 3330 E. Baltimore Street—24
- Alessi, Edward J., 6217 Harford Road—14
- Alessi, Silvio A., 6217 Harford Road—14
- §Allan, Warde B., 6 E. Eager Street—2
- Anderson, Andrew R., 700 Cathedral Street—1
- Anderson, George Woodrow, Johns Hopkins Hospital—5
- Anderson, Townsend W., 01726034 Hdq. 4th Inf. Div., APO 39, % P.M., New York, N. Y.
- Anderson, Walter A., 3001 Shannon Drive—13
- §Andrus, E. Cowles, 24 E. Eager Street—2
- Ankudas, Stanley, 3704 Hillsdale Rd.—7
- Appelfeld, Willard, 2511 Reisters-town Road—17
- Ardinger, Joseph Stanley, Jr., 1230 Augusta Avenue—29
- §Armanas, Henry, 1934 Wilkens Avenue—23
- §Arnold, James G., 11 E. Chase Street—2

* Deceased.

§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

Artigiani, Philibert, 2942 E. Fayette Street—24
 Ascher, Eduard, The Latrobe Apartments—2
 Ashman, Harry, 3700 Garrison Blvd.—15
 Ashman, Leon, 1201 Poplar Grove Street—16
 Ashworth, John William, 1129 St. Paul Street—2
 §Askin, John A., 1406 Eutaw Place—17
 Asper, Samuel P., Jr., Johns Hopkins Hospital—5
 Athey, H. B., 2504 St. Paul Street—18
 Aubrey, John Forsythe, 2583 S. Bayshore Drive, Miami, Fla.
 §Austrian, Charles R., 1417 Eutaw Place—17
 Ayd, Frank J., 2005 E. Monument Street—5
 Ayd, Frank J., Jr., 6231 York Road—12
 Babb, Dudley C., 1100 N. Charles Street—1
 Bacharach, David, 4500 Bonner Road—16
 Bachman, Leonard, 3415 Gwynns Falls Parkway—16
 Baetjer, Walter A., 1101 St. Paul Street—2
 Baggott, Bartus T., 3812 Greenmount Avenue—18
 Bagley, Cecil H., The Latrobe Apts.—2
 §Bagley, Charles, Jr., The Latrobe Apts.—2
 Bagley, Charles, III, University Hospital—1
 Bahnson, Henry T., Johns Hopkins Hospital—5
 Baker, Benjamin M., Jr., 9 E. Chase Street—2
 Baker, Frank William, Jr., A02240719, 5005th Hospital, APO 949 % P.M., Seattle, Wash.
 Baldwin, Ruth Workman, University Hospital—1
 Balfour, Charles Edward, 1103 St. Paul Street—2
 Ballard, Margaret B., Medical Arts Bldg.—1
 Ballich, Nicholas L., 11 E. Chase Street—2

§Ballina, Jones B., 1036 N. Calvert Street—2
 Banfield, Gilbert L., 722 N. Fulton Avenue—17
 Barczak, Edward M., 1603 Glen-eagle Road—12
 §Barnaby, John W., Jr., 1531 E. North Avenue—13
 Barnett, Donald J., X-ray Dept., University Hospital—1
 Barranco, S. H., 436 E. Fort Avenue—30
 Battaglia, D. Thomas, 5829 Belair Road—6
 Bauer, Robert E., 5711 Nasco Place—12
 Baum, Max, 1501 N. Milton Avenue—13
 §Bawden, George A., Medical Arts Building—1
 *Bayer, Ira E., 11 E. Chase Street—2
 Baylin, Morris J., 5418 Park Heights Avenue—15
 *Baylor, John W., 22 E. Gay Street, Westchester, Pa.
 Baylus, Herman H., 1600 Wilkens Avenue—23
 Baylus, Meyer Milby, 2216 Eutaw Place—17
 Beacham, Edmund George, 1721 E. 33rd Street—18
 §Beck, Harry McBrine, 120 Midhurst Road—12
 §Beck, Nathaniel M., 2818 St. Paul Street—18
 Becker, Bernard, Department of Ophthalmology, Washington University, St. Louis, Mo.
 *Beissinger, Heinz F., 5201 Pleasant Street—7
 Benesuns, Joseph G., 110 E. Lombard Street—2
 Benet, Eben Thorpe, Hermit Thrush Rd., Cape Elizabeth, Me.
 Bennett, George E., 4 E. Madison Street—2
 §Benson, Carl F., 5111 York Road—12
 Benson, John Fisher, 46th MASH, APO 8, % Postmaster, San Francisco, California
 Benson, William Prescott, Jr., 1111 Ramblewood Road—12
 Berdiansky, Benjamin, 5004 Ritchie Highway—25

Bereston, Eugene S., 2406 Eutaw Place—17
 Bergland, John McF., 1014 St. Paul Street—2
 Berman, Edgar F., 803 Cathedral Street—1
 Bernheim, Bertram M., 2424 Eutaw Place—17
 Bernstein, Alan, 1109 N. Calvert Street—2
 Berry, Robert Zinn, Medical Arts Building—1
 Berthrong, Morgan, 336 Rosebank Avenue—12
 Bestebreurtje, Annie M., Ruxton 4, Md.
 Betz, Barbara J., 1503 Bolton Street—17
 Biehl, Harold Paul, 11 E. Chase Street—2
 Bindeman, William Wylie, U. S. Army Hospital, Ft. Lawton, Wash.
 Bing, James F., 609 Cathedral St.—1
 §Bird, Joseph Gordon, Northwood Professional Center, 1532 Havenwood Road—18
 Bishop, G. W., Sheridan Avenue and York Road—12
 Bix, Hans, 2516 Linden Avenue—17
 Blair, Emil, Duke University, Durham, N. C.
 Blalock, Alfred, Johns Hopkins Hospital—5
 Blazek, Charles Joseph, 101 E. Biddle Street—2
 Blechman, A. Joel, 3426 Bank Street—24
 Block, Walter P., 509 Drury Lane—29
 §Blum, Joseph S., 1115 N. Calvert Street—2
 Blum, Louis V., 2310 Eutaw Place—17
 Blumberg, Jerome Joachim, 4917 Park Heights Avenue—15
 Bodenheimer, Ernst, 1212 Eutaw Place—17
 Bogorad, Daniel E., 1905 W. Baltimore Street—23
 §Bohlman, Harold R., Medical Arts Bldg.—1
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* Deceased.

§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

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- Borden, Jesse N., 1109 N. Calvert Street—2
- Borden, Melvin N., 5000 Old Frederick Road—29
- Bordley, James, Jr., 2630 Guilford Avenue—18
- Bordley, John Earle, Johns Hopkins Hospital—5
- Borges, Francis Joseph, 2528 Maryland Avenue—18
- Borkovic, George William, Box 76, Romney, W. Virginia
- Borkovich, Katherine H., 11 E Chase Street—2
- Boslow, Harold Meyer, 700 Cathedral Street—1
- Boss, M. Theodore, Medical Arts Bldg.—1
- Bossyns, Albert J., 4122 Kathland Avenue—7
- Bowditch, Sarah H., Cambridge Arms, 34th and Charles Streets—18
- Bowe, Dudley P., 2 W. Read Street—1
- §Bowie, Harry Clay, 1011 N. Calvert Street—2
- Bowie, Helen, 3927 Canterbury Road—18
- §Bowyer, Thomas S., Medical Arts Bldg.—1
- Boyd, Charles Holmes, 24 E. Eager Street—2
- Boyd, Kenneth B., 1114 St. Paul Street—2
- Boyle, J. Brooke, Jr., 1226 St. Paul Street—2
- §Brack, Charles Bernard, 11 E. Chase Street—2
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- Brandon, Russell R., 1606 Kelly Avenue—9
- *Branon, A. Brooks, Cambridge Arms Apartments—18
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- Breitstein, Moses L., 1213 Eutaw Place—17
- Brennan, Thomas J., 5217 Harford Road—14
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- Bronushas, Joseph B. Bernard, 3037 O'Donnell Street—24
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- Brumback, Joseph E., Medical Arts Bldg.—1
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- §Chambers, Thomas R., 18 W. Franklin Street—1
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- Chatard, J. Albert, 15 E. Biddle Street—2
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- Clemens, Raymond L., 3817 Rexmere Road—18
- §Clemson, Earl P., 701 Cathedral Street—1
- Clough, Paul W., 24 E. Eager Street—2
- Cobb, John Candler, 615 N. Wolfe Street—5
- §Coblentz, R. G., 11 E. Chase Street—2
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- Cohen, Harry, 803 Cathedral Street—1
- Cohen, Irvin H., 7433 Rockridge Road—8
- Cohen, Jonas Harold, 6702 Park Heights Avenue—15
- Cohen, Morris M., 1115 St. Paul Street—2
- Cohn, L. Clarence, 3301 N. Charles Street—18
- Colbert, Walter Thomas, 1612 Freedomway N.—13
- Cole, Alfred, 136 S. Hilton Street—29
- Cole, Norman Brown, University Club—1
- Coleman, William J., 2810 Chelsea Terrace—16
- §Collenberg, H. T., 2 W. Read Street—1
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- Colston, J. A. C., 1201 N. Calvert Street—2
- §Compton, Beverley C., 1014 St. Paul Street—2
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- Conn, Jacob Harry, 2325 Eutaw Place—17
- Connolly, Harry John, 13 E. Eager Street—2
- §Constadt, Hans Walter, 814 Medical Arts Bldg.—1
- Conway, William M., 5511 Purdue Avenue—12
- §Cook, Elmer E., Jr., 2431 Maryland Avenue—18
- Cooper, Theodore, 2201 Eutaw Place—17
- Cope, Clyde B., Personnel Health Clinic, Johns Hopkins Hospital—5
- §Copeland, Herbert B., 2237 Eutaw Place—17
- Cordi, Joseph M., 1261 E. Belvedere Avenue—12
- §Cornbrooks, Ernest I., Jr., Medical Arts Bldg.—1
- Costantini, John, 234 S. Conkling Street—24
- §Cotter, Edward Francis, 6 E. Read Street—2
- Council, Wilford A. H., Jr., 9 E. Mount Royal Avenue—2
- Covington, E. Eugene, 828 Park Avenue—1
- §Cox, William Franklin, 3rd, 4006 Deepwood Road—18
- Crimy, Charles P., 2722 E. Monument Street—5
- Crocker, Melvin Hugh, 1204 St. Paul Street—2
- Crosby, Robert MacGonicle Nelson, 11 E. Chase Street—2
- Cross, Ernest S., 1035 N. Calvert Street—2
- Cross, Ernest S., Jr., 4408 Atwick Road—10
- Cross, Richard J., 2230 Garrison Boulevard—16
- Crowe, Samuel J., Tuscany Apartments—10
- Crowther, Aloho H., 4209 Frederick Avenue—29
- Cumin, Milton H., 4302 Springdale Avenue—7
- §Cunningham, Raymond M., 11 E. Chase Street—2
- Currie, Dwight McL., 11 E. Chase Street—2
- §Curtis, Raymond M., 113 Beechdale Road—10
- Daly, Harold Lawrence, Jr., 3300 W. North Avenue—16
- Daly, Miriam Shamer, 3300 W. North Avenue—16
- Dana, Edward R., 4214 Greenway—18
- §Dandy, Walter E., Jr., Apt. 62A Wherry, Fort Campbell, Ky.
- Daniels, Thomas F., 6 E. Eager Street—2
- D'Antonio, Joseph, 127 Riverthorn Road—20
- Darby, William Arthur, Medical Arts Bldg.—1
- Davidov, Nathan J., 3218 Eastern Avenue—24
- Davidson, Charles Nuchols, 5900 Lakehurst Drive—10
- Davidson, Nachman, 2403 Ken Oak Road—9
- Davies, Arthur J., 800 W. 33rd Street—11
- Davis, E. Hollister, 3301 N. Charles Street—18
- Davis, Frank Willard, Jr., 11 E. Chase Street—2
- Davis, John R., Jr., Medical Arts Building—1
- Davis, Marvin Hersch, 803 Cathedral Street—1
- Davis, W. Bowdoin, 701 Cathedral Street—1
- §Day, Newland Edward, 4 E. 33rd Street—18
- Deane, Garrett E., 5402 Edmondson Avenue—29
- Debuskey, Matthew, 2412 Eutaw Place—17
- DeCarlo, John, Jr., 1211 Cochran Avenue—12
- Deckert, W. Allen, 1114 St. Paul Street—2
- De Hoff, George W., 2020 N. Charles Street—18
- §De Hoff, John Burling, 2020 N. Charles Street—18
- Deibel, Harry, 1224 Hanover Street—30
- Delfs, Eleanor, Johns Hopkins Hospital—5
- Demarco, Salvatore J., Jr., 715 N. Charles Street—1
- Dennis, John Murray, Medical Arts Building—1
- Denny, Walter L., Brady Urological Institute, Johns Hopkins Hospital—5
- De Vincentis, Michael Louis, 11 E. Chase Street—2
- Dickey, Francis G., 736 Northern Parkway—12

§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

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 §Diggs, Everett S., 11 E. Chase Street—2
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 Dixon, Darius McClelland, Medical Arts Bldg.—1
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 §Dobihal, Louis Charles, 447 N. Kenwood Avenue—24
 Dodd, Robert B., University Hospital—1
 Dodd, William A., 700 N. Charles Street—1
 Doeller, Charles Henry, Jr., 1025 N. Calvert Street—2
 Donner, Leon, 4513 Pimlico Road—15
 Doran, William T., Jr., 221 W. Lánvale Street—17
 Dorf, Herman J., 3103 Garrison Blvd.—16
 §Dorman, John William, Jr., 1305 Round Hill Road—18
 Douglass, Carleton Cecil, 15 E. Biddle Street—2
 §Douglass, Louis H., University Hospital—1
 Doukas, James A., 3810 Lochern Drive—7
 Drenga, Joseph F., 209 S. Chester Street—31
 Drozd, Joseph, 240 S. Ann Street—31
 Dudley, Albert Henry, Jr., 1201 N. Calvert Street—2
 Duffy, William C., 1120 St. Paul Street—2
 §Dugan, Hammond J., Jr., 15 E. Biddle Street—2
 Dumler, John C., Medical Arts Building—1
 Dunnigan, William C., 4916 Harford Road—14
 Dwyer, Frank P., Jr., 216 Montrose Avenue—28
 Eastland, John Sheldon, Medical Arts Bldg.—1
 §Eastman, Nicholson J., Johns Hopkins Hospital—5

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§ Wife is a member of the Woman's Auxiliary to the Medical and Chirurgical Faculty.

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 Edgerton, Milton T., Johns Hopkins Hospital—5
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 Edmonds, Charles William, 2746 Alameda Boulevard—18
 Edmunds, Page, 4417 Underwood Road—18
 §Edwards, C. Reid, University Hospital—1
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 Eleder, Franklin Charles, 2201 Echodale Avenue—14
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 §Ellis, Francis A., 8 E. Madison Street—2
 §Ellison, Emanuel S., 107 E. West Street—30
 Englehart, William P., 6308 Holly Lane—12
 §English, Max R., 5713 Belair Road—6
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 Ephraim, Meyer, 443 E. 25th Street—18
 Erwin, John J., Medical Arts Bldg.—1
 Evans, John, Medical Arts Bldg.—1
 Everett, Houston Spencer, 11 E. Chase Street—2
 §Ewald, August L., 36 York Court—18
 Faraino, Frank A., Medical Arts Building—1
 Farber, George J., 1037 St. Paul Street—2

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 Feldman, Maurice, 3602 Ford's Lane—15
 Feldman, S. Charles, 1440 E. Baltimore Street—31
 Fenby, John S., 3522 Greenmount Avenue—18
 §Ferguson, W. Richard, 6 East Eager Street—2
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 Filtzer, David Leonard, 1411 Eutaw Place—17
 Fineman, Jerome, 3700 Garrison Blvd.—15
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 Finkelstein, Ruth, Medical Arts Building—1
 §Finney, George Gross, 2947 St. Paul Street—18
 Finney, John M. T., Jr., 2947 St. Paul Street—18
 Firor, Warfield M., 1101 N. Calvert Street—2
 §Firor, Whitmer B., 1100 N. Charles Street—1
 Fishel, Elliott Raphael, 821 Chauncey Avenue—17
 Fisher, A. Murray, 18 E. Eager Street—2
 Fisher, Russell S., 700 Fleet Street—2
 Fisher, William A., Jr., 20 Blythewood Road—10
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- Foster, Herbert M., 2824 St. Paul Street—18
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- Frank, Jerome D., 603 W. University Parkway—10
- §Franklin, Haswell D., 1123 St. Paul Street—2
- §Franz, J. Howard, 1127 St. Paul Street—2
- Fravel, C. Richard, 117 Dumbarton Road—12
- Frederickson, Howard N., 3813 Patterson Ave.—7
- Freedom, Leon, 1031 St. Paul Street—2
- §Freeman, Norman Randolph, Jr., 210 Northway—18
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- Frey, Edward L., Jr., 2 W. Read Street—1
- Frey, E. William, 1928 Pennsylvania Avenue—17
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- Friedman, Hyman P., 1319 Light Street—30
- Friedman, Joseph, 404 E. North Avenue—2
- Friedman, Marion, 1737 E. North Avenue—13
- *Friedman, Paul N., 3804 Fairview Avenue—16
- Fuller, Harvey L., 5718 Ridgedale Road—9
- Furnari, Joseph C., University Hospital—1
- Furstenberg, Frank F., 812 Park Avenue—1
- Fusting, William H., 4230 Loch Raven Boulevard—18
- Futcher, Palmer H., Department of Medicine, Johns Hopkins Hospital—5
- Futterman, Perry, Latrobe Apartments—2
- Gaber, Jerome, Stevenson P.O., Stevenson, Md.
- Gaither, Ernest H., 12 E. Eager Street—2
- Gallant, Leonard J., The Latrobe Apartments—2
- Galvin, Gerald A., 322 Suffolk Road—18
- *Galvin, Thos. K., 113 W. Monument Street—1
- Gann, Mark E., 2800 Lawina Road—16
- Gardner, Francis Sidney, Jr., 1684 Waverly Way—12
- Gareis, Louis C., 1651 Northwick Court—18
- §Garis, Robert William, 1103 St. Paul Street—2
- Garlick, William L., 700 N. Charles Street—1
- §Garrett, Richard M., Medical Arts Building—1
- Garrison, Alfred S., 2 E. Read Street—2
- Gaskel, Jason H., 637 S. Conkling Street—24
- Gaver, Leo J., 1 Mallow Hill Avenue—29
- §Gay, Leslie Newton, 1114 St. Paul Street—2
- Gebhardt, Robert William, 3711 Monterey Road—18
- Gehlert, Sidney R., Jr., 4700 Pennington Avenue—26
- Gellman, Moses, 1411 Eutaw Place—17
- Genecin, Abraham, 1109 N. Calvert Street—2
- Gentry, William D., Jr., Heatherfield Road—10
- Geraghty, Francis Jos., 3047 St. Paul Street—18
- Geraghty, Wm. R., 2225 St. Paul Street—18
- Gerlach, James Johnson, 4 E. Eager Street—2
- Gibbons, J. Robert, 3 Elmhurst Road—10
- Gibbs, Gordon E., University Hospital—1
- Giering, Herman J., 3906 Parkside Drive—6
- Gilkes, Evan A., 601 N. Calhoun Street—17
- Gillis, Andrew Colin, 1033 N. Calvert Street—2
- Gillis, Francis W., 1800 N. Charles Street—1
- Gilmore, William E., 108 E. 33rd Street—18
- Gimbel, Harry S., 4605 Edmondson Avenue—29
- Ginsberg, Milton, 3504 Erdman Avenue—13
- Ginsburg, Leon, 529 N. Charles Street—1
- Gladue, J. Raymond, 530 Beaumont Avenue—12
- Glass, Frederic Arthur, 845 Park Avenue—1
- Glassman, Lionel, 6002 Wallis Avenue—15
- §Glick, Samuel S., 3914 Park Heights Avenue—15
- Gliedman, Lester H., Johns Hopkins Hospital—5
- Gluck, Francis Wilcox, 100 W. University Parkway—10
- Gluck, Julius C., 5356 Reisterstown Road—10
- Goldbach, Leo John, 6 E. Eager Street—2
- Goldberg, Herman K., 807 Cathedral Street—1
- Goldberg, Raymond B., 803 Cathedral Street—1
- Goldberg, Sigmund, 1422 Park Avenue—17
- Goldberg, Sylvan D., 4412 Elderon Avenue—15
- Goldberg, Victor, 1916 E. 30th Street—18
- Goldman, Abram, 3501 Powhatan Avenue—16
- Goldman, Harris, 3507 Garrison Boulevard—15
- Goldmann, Harry, 2326 Eutaw Place—17
- §Goldsborough, Charles R., 2923 St. Paul Street—18
- §Goldstein, A. E., 3505 N. Charles Street—18
- Goldstein, Eugene O., 1310 Churchill Drive—8
- Goldstein, Marvin, 5334 Liberty Heights Avenue—7
- Goldstone, Herbert, 1810 Eutaw Place—17
- Golley, Kyle W., 5103 Harford Road—14
- Goodman, Howard, 1513 N. Milton Avenue—13

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- Goodman, Louis E., 1211 Eutaw Place—17
- Goodman, Sylvan Chauncey, 2202 Park Avenue—17
- Gordon, Harry H., Sinai Hospital—5
- Gordy, Lyle L., 5106 Harford Road—14
- Gorten, Martin K., 4 E. 32nd Street—18
- Gould, David M., 3709 Sequoia Avenue—15
- Gould, John Joseph, 14 N. East Avenue—24
- Govatos, George, Med. Arts Bldg.—1
- Govons, Sidney Robert, 2311 Ken Oak Rd.—9
- Grabill, James R., 1945 W. Baltimore Street—23
- Grafflin, Allan L., 215 Edgevale Road—10
- §Graham, R. Walter, Jr., 1014 St. Paul Street—2
- Granoff, Hymen L., 2240 Eutaw Place—17
- Gray, Watson W., 1014 St. Paul Street—2
- Graziano, Theodore J., 4019 Alameda Blvd.—18
- Green, John Summerfield, III, 6309 Pinehurst Road—12
- Greenberg, Alfred, 2912 Wynham Road—16
- Greenberg, Sahler M., 4613 Eastern Avenue—24
- Greenwald, Leon, 1801 Eutaw Place—17
- Grempler, Walter E., 4513 Old Frederick Road—29
- Grenzer, William H., 1520 E. 33rd Street—18
- Grimes, S. Butler, 100 W. University Pkwy.—10
- Grob, David, 4017 Elderon Avenue—15
- Grose, William Edwin, 1201 N. Calvert Street—2
- Gross, Joseph Bernard, 2404 Eutaw Place—17
- Grossman, I. Karl, 1212 N. Patterson Park Avenue—13
- Grott, Harold Allan, 8100 Harford Road—14
- Grubb, Wilson, 4 E. 33rd Street—18
- Grumbine, Francis L., 411 N. Chapelgate Lane—29
- Gubnitsky, Albert, 5415 Park Heights Avenue—15
- Gundersheimer, Herbert N., Cordova Apartments, Lake Drive—17
- §Gundry, Lewis P., Relay 27, Md.
- Gundry, Rachel K., Athol, Catonsville—29
- Gutman, Isaac, 817 St. Paul Street—2
- Guttmacher, Manfred S., 1109 N. Calvert Street—2
- Guyton, J. Willis, 1207 E. 36th Street—18
- Haase, John Henry, 4218 Harford Road—14
- Hachtel, Frank W., 122 W. Lafayette Avenue—17
- Hahn, Richard D., 1823 Park Avenue—17
- Haines, John S., 11 E. Chase Street—2
- Hall, Arthur T., Jr., 2 E. Read Street—2
- Hall, Elmer G., 1631 E. North Avenue—13
- Hall, William S., 215 Woodlawn Road—10
- Hamburger, Louis P., 1207 Eutaw Place—17
- Hamburger, Louis P., Jr., 1207 Eutaw Place—17
- Hammer, Howell I., 1929 Edmondson Avenue—23
- Hanchett, Richard B., Medical Arts Building—1
- Handelsman, Jacob Charles, 1112 N. Calvert Street—2
- Hankin, Samuel J., 2331 Eutaw Place—17
- Hanson, Arthur M., 40 Maple Drive—28
- Harbold, Harold V., 4706 Harford Road—14
- Hardy, Janet B., Glenarm, Md.
- Harmon, Louis E., 2224 Madison Avenue—17
- Harper, Paul, 615 N. Wolfe Street—5
- Harris, S. Elliott, 3701 Calloway Avenue—15
- Harris, Thomas W., 1824 W. Franklin Street—23
- Harrison, Clinton Rabbe, 6 E. Eager Street—2
- Harrison, Edmund P. H., 2903 N. Charles Street—18
- Harrison, Harold E., 3001 Fordney Lane—7
- Hart, Jeremiah A., 311 W. 31st Street—11
- Hartman, Oscar, 1801 Eutaw Place—17
- Hartmann, William L., 5831 The Alameda—18
- Hartz, Alvin S., 1104 N. Butler, Farmington N. M.
- Hartz, Jerome, 11 E. Chase Street—2
- §Harvey, A. McGehee, Johns Hopkins Hospital—5
- Harvey, John Collins, 500 N. Washington Street—5
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- Hawkins, John Frederick, Jr., Dividing Road, Manhattan Beach, Severna Park, Md.
- §Haws, John March, 1201 N. Calvert Street—2
- Hayleck, Mary L., 4401 Underwood Road—18
- Hayward, Eugene H., 115 E. Eager Street—2
- Healy, Robert F., Medical Arts Bldg.—1
- Hebb, Donald B., Cockeysville, Md.
- Hecker, Erwin, 3668 Forest Garden Avenue—7
- Heghinian, Jeanette R., 2212 South Road—9
- Heldrich, Frederick Joseph, Jr., 1047 Cooks Lane—29
- Helfrich, Raymond F., 519 Lyndhurst Street—29
- §Helfrich, William G., 5006 Roland Avenue—10
- Henning, Emil Heller, Jr., 601 Winans Way—29
- Hensen, Henry Mathies, 0261356, 279th Station Hospital, APO 742, % Postmaster, New York, N. Y.
- §Herman, N. B., 1041 St. Paul Street—2
- Herold, Paul Garmer, 1222 Walters Avenue—12
- §Hersperger, W. Grafton, 12 E. 33rd Street—18

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 Hills, Ralph G., 18 E. Eager Street—2
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 §Hirshfeld, John H., 6919 Harford Road—14
 Hobelmann, Charles F., 3915 Juniper Road—18
 Hoffman, Elmer, 3501 St. Paul Street—18
 Hoffman, Reuben, 3602 Forest Park Avenue—16
 Hogan, J. F., 7 E. Preston Street—2
 Hogan, John F., Jr., 8041st Army Unit, % P.M., San Francisco, Calif.
 Hollander, David H., 5514 Kemper Road—10
 Holljes, Henry Wirt Duvall, 3308 W. North Avenue—16
 Hood, Bowman J., 317 Broxton Road—12
 Hooper, Z. Vance, 3534 Ellerslie Avenue—18
 Hope, Daniel, Jr., Rockwell & Westchester Aves.—28
 §Hopkins, H. Hanford, 1201 N. Calvert Street—2
 §Hopkins, James E. T., 104 W. Madison Street—1
 Hopkins, John Vernon, 129 E. Redwood Street—2
 Horning, Edward Douglas, 18 W. Franklin Street—1
 Horton, William Preisz, 6831 Blenheim Road—12
 Howard, John Eager, Johns Hopkins Hospital—5
 Howard, John Tilden, 12 E. Eager Street—2
 Huffer, Virginia, University Hospital—1
 §Hull, Harry Clay, Medical Arts Bldg.—1
 Hulla, Jaroslav, 2214 E. Fayette Street—31

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 Hunner, Guy Le Roy, The Greenway Apartments—18
 Hurwitz, Abraham B., 2200 Garrison Boulevard—16
 Hurwitz, Chester E., 2218 Eutaw Place—17
 Hutchins, Amos F., 1227 N. Calvert Street—2
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 Hyman, Nathan B., 1805 Eutaw Place—17
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 Jacobs, Louis L., 1700 Eutaw Place—17
 Jacobson, Meyer William, 2310 Eutaw Place—17
 Jaffe, Marvin, 3935 Duvall Avenue—16
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 Jaworski, Melvin J., 2711 Eastern Avenue—24
 Jennings, F. Leslie, Medical Arts Bldg.—1
 Jeppi, Joseph, 10 E. Read Street—2
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 §Jewett, Hugh J., 1201 N. Calvert Street—2

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 §Johnson, Edward S., 203 Chancery Road—18
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 Johnson, Robert W., Jr., 4 E. Madison Street—2
 Johnson, Robert W., III, 1014 St. Paul Street—2
 Johnson, William R., Medical Arts Bldg.—1
 Jones, Benjamin F., 5F Garden Apartments—10
 Jones, Everett D., 101 E. Biddle Street—2
 Jones, Georgeanna Seegar, Medical Arts Building—1
 Jones, H. Alvan, 1107 St. Paul Street—2
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 Kaltreider, D. Frank, 1526 Northwick Road—18
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 §Kardash, Theodore, Medical Arts Building—1
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 Kayser, Fayne Albert, Medical Arts Bldg.—1
 Keller, Charles J., 222 W. Monument Street—1
 *Kelly, Bernard V., National Marine Bank Bldg.—2
 §Kelly, Vernon C., 11 E. Chase St.—2
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 §Keown, Lauriston L., 431 E. Lake Avenue—12
 Kerman, Edward F., 3700 Liberty Heights Avenue—15
 §Kern, Howard M., Esplanade Apartments—17
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 *Kieffer, Richard F., 200 W. Baltimore Street—1
 Kieffer, Richard F., Jr., 5220 Springlake Way—12
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 Kimzey, F. J., 2700 Harford Road—18
 King, John Theodore, 1210 Eutaw Place—17
 King, Joseph D. B., 404 Hawthorn Road—10
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 Kirkpatrick, Crawford N., Jr., 6 E. Eager Street—2

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 §Klimes, Louis F., 2623 E. Monument Street—5
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 §Kloman, E. H., 44 W. Biddle Street—1
 Klotz, Ben, 817 St. Paul Street—2
 Knipp, George A., 4116 Edmondson Avenue—29
 Knipp, Harry Lester, 4116 Edmondson Avenue—29
 Knowles, F. Edwin, Jr., 513 N. Charles Street—1
 Knox, James H. Mason, III, 600 W. Belvedere Ave.—10
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 Kohlerman, Nicholas John, The Latrobe—2
 Kohn, Walter, 102 E. Fort Avenue—30
 §Kolman, Lester N., 3700 Park Heights Avenue—15
 §Kolodner, Louis J., 2502 Eutaw Place—17
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 Kress, Milton B., Medical Arts Building—1

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 §Krieg, Edward L. J., 5019 Old Frederick Road—29
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 Krumrein, Louis Frederick, 722 N. Kenwood Avenue—5
 Kunkowski, Andrew, 2529 Eastern Avenue—24
 Kurland, Albert A., 6207 Winner Avenue—15
 Kyper, Fred T., 421 Medical Arts Building—1
 Lachman, Harry, 2322 Callow Avenue—17
 Laforest, Albert L., 822 N. Bond Street—5
 Lally, Leo A., 3517 Edmondson Avenue—29
 Lambros, Byruth Lenson, 213 Mallow Hill Rd.—29
 §Lang, Milton Charles, 2117 Belair Road—13
 Langeluttig, H. Vernon, 715 N. Charles Street—1
 Langworthy, Orthello R., 1503 Bolton Street—17
 Lapp, Herbert Walter, 8 N. Bernice Avenue—29
 Lasell, Eldridge L., Greenway Apartments, 34th and Charles Streets—18
 Latham, Ernest Floyd, 1010 St. Paul Street—2
 Latham, Doris Vivian, 1010 St. Paul Street—2
 Laukaitis, Joseph, 679 Washington Blvd.—30
 Lavenstein, Arnold F., 5715 Oakshire Road—9
 Lavy, Louis T., 1844 W. North Avenue—17
 Leach, C. Edward, 14 E. Eager Street—2
 Lebo, Lester, 1801 Eutaw Place—17
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 Leftwich, Charles I., 2180 Melvia Street, Berkeley, Calif.
 Legge, John E., 700 Cathedral Street—1

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 McCarty, Harry D., 37 W. Preston Street—1
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 McCormack, Lloyd L., 111 E. Preston Street—2
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 McDonnell, Edmond J., 4 E. Madison Street—2
 McElwain, Howard B., 31 E. North Avenue—2
 McFadden, Robert B., 19 Wyndcrest Avenue—28
 McGrady, Charles Winfred, Jr., University Hospital—1
 McGrady, Kathleen Reilly, University Hospital—1
 McGrath, Denis Joseph, 1 E. Randall Street—30
 §McKay, John Nelson, 3503 W. Franklin Street—29
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- §Markley, Raymond Law, Medical Arts Building—1
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- Marshall, Curtis, Johns Hopkins Hospital—5
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- Meranski, Israel P., 3354 Dolfield Avenue—15
- Merkel, Walter C., Union Memorial Hospital—18
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- Milan, Albert Richard, 320 E. 33rd Street—18
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- Miller, Harry A., 2452 Eutaw Place—17
- Miller, Isaac, 1228 S. Charles Street—30
- Miller, Jacob M., 1613 E. Baltimore Street—31
- Miller, James Patton, 804 Cathedral Street—1
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- Moore, Marcus W., Sr., 1371 N. Carey Street—17
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- Racusin, Nathan, 206 S. Gilmore Street—23
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- Reckling, Ralph Weeden, 520 N. Fulton Avenue—17
- Reese, Fred M., 330 N. Charles Street—1
- §Reifschneider, Charles A., 104 W. Madison Street—1
- Reifschneider, Herbert E., 104 W. Madison Street—1
- §Reiter, Robert A., 3408 Windsor Avenue—16
- Renner, William F., 11 West 29th Street—18
- §Revell, Samuel T. R., Jr., University Hosp.—1
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- Richards, Esther Loring, 41 W. Preston Street—1
- Richardson, Edward H., 9 E. Chase Street—2
- Richardson, Edward H., Jr., 9 E. Chase Street—2
- Richardson, Horace K., 11 E. Chase Street—2
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- Sawyer, William H., Jr., 4928 West Hills Road—29
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- Schapiro, William B., 2415 Eutaw Place—17
- Schenker, Paul, 2424 Eutaw Place—17
- Scher, Ernest, 1701 Eutaw Place—17
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- Scherlis, Leonard, 1214 N. Calvert Street—2
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- §Schimunek, Emanuel, 842 S. East Avenue—24
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- Schwartz, Daniel J., 2320 Eutaw Place—17
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- Shernan, Harry Donald, 2326 Eutaw Place—17
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- Siwinski, Thaddeus Charles, 807 Wellington Road—12
- *Skillman, Wilbur F., 6 E. Biddle Street—2
- Skloven, Joseph, 7122 Harford Road—14
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- Slockbower, Edith Trepton, 1101 N. Calvert Street—2
- Small, Mary Louise, 16 W. Read Street—1
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- Smith, Harry Bryant, 7201 Oxford Road—12
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- Smith, William Henry, 3429 Chestnut Avenue—11
- Smith, Winford H., 100 W. University Parkway—10
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- Snyder, Nathan, 1200 St. Paul Street—2
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- Sunday, Stuart D., 201 E. 33rd Street—18
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 Hoyt, Irvin G., Queenstown, Md.
 Layton, C. Rodney, Centreville, Md.
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 Martin, G. William, Jr., Queenstown, Md.
 Sattelmaier, Theodor, Stevensville, Md.

St. Mary's County

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 Greenwell, Francis Floyd, Leonardtown, Md.
 Guyther, J. Roy, Mechanicsville, Md.
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WIDOWS OF FORMER MEMBERS OF THE MEDICAL AND CHIRURGICAL FACULTY WHO ARE MEMBERS OF THE WOMAN'S AUXILIARY

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DIRECTORY—TRANSACTIONS

The preceding pages 241–273, which list the membership of the Medical and Chirurgical Faculty from March 31, 1953 through March 31, 1954, are a part of the Transactions for 1954.

NEW HILL-BURTON EXPANSION BILL IS REPORTED TO HOUSE

THE AMA Washington Letter, No. 61

The House Interstate and Foreign Commerce Committee on March 3 favorably reported a new bill (H.R. 8149) for expanding the Hill-Burton hospital construction program to include diagnostic or treatment centers, hospitals for the chronically ill, rehabilitation centers and nursing homes. It supersedes H.R. 7341. The same appropriations are asked: \$182 million over three years, with \$2 million for planning and surveys, \$20 million annually for diagnostic or treatment centers, a like amount for hospitals for the chronically ill, \$10 million for rehabilitation facilities and a like amount for nursing homes. Administration (by states, under regulations drawn up by the U.S. Surgeon General) would remain generally the same as in H.R. 7341. The changes include:

U.S. Share. Under the earlier bill, states would have been required to match federal money dollar-for-dollar. The new bill adopts the regular Hill-Burton procedure for matching, except that a state may decide on a 50-50 matching program. “. . . *For All the People.*” The new bill restates the purpose of the original Hill-Burton law to help states to provide facilities “for furnishing to *all their people* adequate services.” It is understood that this would rule out facilities sponsored by a labor or fraternal organization or a prepaid health plan unless the general public were allowed full and unrestricted use of the facilities. ‘*Nonprofit*’ and ‘*Public*’ *Requirements.* The first bill limited grants to “nonprofit” centers or hospitals. The second changes this to read “public and other nonprofit” centers or hospitals. The earlier bill required that centers and nursing homes be “under the professional supervision of persons licensed to practice *medicine* in the state.” The second broadens this by also making eligible centers and nursing homes that are “operated in connection with a hospital.” *Restriction on Diagnostic-Treatment Centers.* A new restriction is written into the bill concerning diagnostic or treatment centers. If they are not public, they would have to be operated by or be a part of “a corporation or association which owns and operates a nonprofit hospital.” This would bar U.S. grants to a group of physicians who want to set up a center, unless they also operate a nonprofit hospital. *Bi-State Facilities.* Under the new bill it would be possible for a state to have a portion of its allocation transferred to another state to help in the construction of a facility for use of both states. *Restriction on Disposition.* The first bill would have authorized the federal government to recover its proportionate share of a facility converted to private-profit use within 20 years after construction. The new bill would allow the U.S. to recover if the facility were sold or transferred at any time.

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82% NEEDY AGED ‘ABLE TO CARE FOR SELVES’

AMA Washington Letter, No. 64

A new survey by the Bureau of Public Assistance indicates that 82% of the needy aged receiving public assistance are able to care for themselves, and less than 4% are bedridden. The study also found that 80% of the recipients are more than 70 years of age and 25% are past 80. It was determined that although most aged persons live in cities, a majority of those receiving public assistance live in rural areas.

ENLISTED STATUS PROPOSED FOR SOME PHYSICIANS

The AMA Washington Letter, No. 61

To make it possible to use suspected subversive physicians and dentists in noncommissioned rather than commissioned status, Defense Department is asking for new legislation. The bill, an amendment to the Doctor Draft act, would authorize the services "to utilize in his professional capacity in an enlisted grade or rank . . ." any person drafted or called to duty "who fails to qualify for or accept a commission, or whose commission is terminated." The bill is awaiting Budget Bureau approval. A recent Court of Appeals decision ordered the Army to commission or discharge Dr. Herbert L. Nelson, a dentist, who refused to fill out his loyalty questionnaire. The now celebrated case of Dr. Irving Peress, another dentist, is similar, except that in this instance the Army kept him on duty as a commissioned officer after learning that he had not filled out the loyalty questionnaire. (Defense Department has announced it will need about 4,500 physicians for the fiscal year starting next July 1).

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HEARINGS

THE AMA Washington Letter, No. 61

H. R. 7914 (Poff) Granting Federal Charter to National Fund for Medical Education. A subcommittee of the House Judiciary Committee received testimony March 1 from witnesses, including a representative of the American Medical Association, on the bill (H.R. 7914) to grant a federal charter to the National Fund for Medical Education. Dr. Louis H. Bauer, former president of the AMA and a trustee of the Fund, testified that the granting of a charter to the Fund would lend it prestige and aid in its job of financing medical education needs from private rather than governmental sources. Dr. Bauer noted that the bill was preferred to the Senate version (S. 1748) because it stressed raising and disbursing funds from private sources and provided for the inclusion of four physicians on the board.

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VA REPORT FOR FISCAL 1953 RELEASED

The AMA Washington Letter, No. 62

The Veterans Administration report for fiscal 1953 shows that the average daily patient load of veterans in VA and non-VA hospitals remained about the same as the preceding year: 104,482. Admissions to hospitals came to 468,349, about 27,000 fewer than in fiscal 1952. About 23,000 eligible veterans were awaiting admission, 1,000 more than the year before. (Of these, only three were service-connected cases; they had been offered admission, but preferred to wait for hospitals of their choice.) Residency trainees at 69 VA hospitals and one regional office totalled 2,014. Most popular residency programs were in internal medicine (599), general surgery (533), and psychiatry (291).

Maryland STATE MEDICAL JOURNAL

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EDITORIAL

GEORGE H. YEAGER, M.D.*

Through the efforts of Dr. Harry F. Klinefelter, Jr., and with the endorsement of Dr. Harold B. Plummer, the immediate past president of the Maryland Academy of General Practice, a series of articles will be published in this JOURNAL, designed to present current specialized knowledge in an easily assimilated manner. Each article is being presented by an authority recognized in his respective field.

It is realized that the average practitioner does not have either the time or inclination to read and study current literature, particularly if it contains obscure figures and confusing statistics. New drugs and new modes of therapy are being developed so rapidly that stability with reference to their usage becomes difficult. Concepts that are acceptable today frequently become unacceptable tomorrow.

Today the thinking of the entire medical profession is toward better education of all its members. The development of the American Academy of General Practice has focused additional attention upon the necessity and need of graduate level information for the general practitioner, with emphasis upon current trends. The chartering of the Maryland Academy of General Practice by the American Academy of General Practice has emphasized such need at the local level. It is hoped that the present series of articles will prove to be a worthwhile contribution toward that need.

* Editor, Maryland State Medical Journal and President-elect, Medical and Chirurgical Faculty.

Scientific Papers

Chest Diseases in General Practice

WARDE B. ALLAN, M.D., F.A.C.P.*

In the past few years there has been an increase in the number of patients with lung changes that present a problem for the general practitioner in his office practice. This increase has been due, in part at least, to the availability of x-ray facilities. The mobile units and routine chest x-ray surveys are ever increasing their scope. The method of reporting the findings to the family doctor is commendable. In the cases in which positive findings are reported the intelligent follow up by the physician is of vital importance. Many positive reports need not be pursued further because the lesion may be one of long standing and stable. However, in all other cases a large or regular 14 x 17 film should be requested. A lateral film is also of importance because the lesion usually can be located more accurately. In many cases this information alone will permit an accurate diagnosis. Other x-ray procedures may be employed, the most revealing being bronchograms and laminograms.

Chest diseases in general practice usually fall into one of several groups. Though all pulmonary lesions cannot be covered, the important ones will be outlined.

The common bacterial infections of the bronchi and the lungs are seen more commonly now in general practice than in hospital practice. Acute bronchitis and the pneumonias can be handled adequately in the home except when complications arise. At this point a word of warning is definitely in order. It is unwise to prescribe sulfonamides or antibiotics or a combination of these indiscriminately just because

the patient has fever. We must appreciate that these therapeutic measures are life saving but it has been recognized that resistant strains of organisms have developed. This serious state of affairs can be blamed on indiscriminate and inadequate drug therapy.

Bronchiectasis is a common condition that requires careful evaluation before therapy is instituted. The history of a chronic cough, copious sputum and hemoptysis is a well known triad of symptoms. However, all such cases are not due to bronchiectasis. As a rule, the usual x-rays of the chest fail to confirm or disprove the presence of marked or minimal ectasia. Where this condition is suspected three important steps are essential. First, sputum examinations and cultures are made. Sensitivity studies of the isolated organisms to the various antibiotics should be requested. Second, bronchoscopy by a competent and experienced operator should be done and third, bronchograms are then requested. All branches of the bronchial tree should be visualized before any definite therapy is advised.

The only procedure by which a "cure" can be accomplished is to have the involved segments or lobes removed by operative means. This procedure is one which should be done only by qualified chest surgeons.

Many cases of bronchiectasis cannot be submitted to surgery, namely in patients with extensive disease and in the older patients. These cases are often challenging problems. General medical procedures can relieve these sufferers. Postural drainage, properly taught and performed to get good results in the production of sputum, is an invaluable aid. If this procedure is

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done in the morning and evening it will give the patient better days and nights. The use of bronchial dilators (Isuprel, 1:200) in a nebulizer before drainage is most helpful. The addition of Alevaire has proven useful in liquifying the secretions and promoting better drainage. In addition to these measures, it is often helpful to have these patients on prophylactic sulfonamides or one of the antibiotics through the winter months. This has reduced the incidence of pulmonary complications which commonly follow upper respiratory tract infections.

Tuberculosis is a disease that should be recognized by physicians in general practice. When a suspicious lesion is found, it is the duty of the practitioner to ascertain whether or not tubercle bacilli are present. A three day collection of sputum in a sterile glass jar can be used for smear and culture. The physician can be helped by one of the several private laboratories in the state. The facilities of the city and state health department laboratories are also available. These laboratories can also do gastric washings for the identification of tubercle bacilli. Once a diagnosis has been established it is most important to institute therapy. As a general rule it is unwise for anyone not skilled in the intricacies of tuberculosis to embark on a prolonged course of treatment for that disease. It is our opinion that such therapy should be under the direction of someone who devotes the majority of his time to such a practice.

As we have mentioned, the miniature films have brought to light solitary asymptomatic lesions of the lungs, so-called "coin lesions." From the statistics it is known that an alarming percentage of these are malignant. For that reason all such lesions should be resected. The possible exception to such a radical procedure is in those instances where the "coin lesion" contains calcium. Many observers believe that this type of lesion, known as a tuberculoma, is likewise a potential hazard to the patient and should be removed. Solitary tumors of this type

are removed by a wedge resection, segmental resection or lobectomy.

Cancer of the lung by all statistics is on the increase, a very real increase rather than due to the fact that it is more easily recognized. It is unfortunate that this condition is not always recognized early. Pneumonectomy is the only treatment that has brought about a "cure." The results are, on the whole, not too gratifying. However, even in most instances, it is advisable to perform a thoracotomy. If the tumor is classified as inoperable, palliative procedures have proven most helpful. X-ray therapy as an adjunct to surgery is always worth consideration. Radiation therapy has proven valuable in cases of superior sulcus tumors and has given relief from the pains of local invasion and metastases. The newer drugs have been tried and of these the nitrogen mustards are the best. The mustards frequently control cough, chest pain and bone pain.

It is urged that all lung lesions be quickly evaluated and be placed in the hands of those people best able to treat such cases either by medical means or by surgical procedures.

One of the most disabling of pulmonary diseases is emphysema. The causes and mechanisms are not clearly understood. The respiratory distress in the condition is progressive and crippling. In the treatment of this condition broncho dilators, respiratory exercises and positive pressure oxygen have proven to be of considerable value.

Finally, it is important to know when to take an x-ray of the chest. It is not always possible to obtain an x-ray of the chest as a part of a routine physical examination. It may add a financial burden to any given patient. However, x-rays of the chest should be taken if the patient has a persistent cough, or has noticed even a fleck of blood in the sputum after coughing. Dull aching pain in the chest or pain in the shoulder and arm are very strong indications for such a study and x-rays should also be taken in all cases of acute

pulmonary infections after recovery from the acute episode. In conclusion, it is urged that all patients with pulmonary disease be carefully studied. Specific treatment of any pulmonary

lesion should not be instituted until a definite diagnosis has been established.

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AMA TESTIFIES ON HEALTH BILLS BEFORE SENATE SUBCOMMITTEE

The AMA Washington Letter, No. 67

Dr. David B. Allman, chairman of the AMA's Committee on Legislation, on April 13 testified before the Senate Labor and Welfare Committee's Health Subcommittee on four of the major health bills proposed by the Eisenhower administration. "In general, we agree with the stated purposes of these proposals," Dr. Allman said, "but we believe that considerable more study is necessary to determine the most desirable ways to accomplish these objectives." Following is a summary of Dr. Allman's testimony on each of the bills:

Public Health Grants (S.2778). The bill proposes that the present grants for designated diseases be eliminated in favor of three new types of grants, (a) for public health services in general, (b) for extension and improvement of service, and (c) for "unique projects," or pilot operations. Dr. Allman recommended that the proposed new type one and two grants be lumped together, with the state public health officer using the funds as he sees fit, and that the Public Health Service surgeon general be required to consult with state health authorities or an advisory committee before allocating money for type three projects, which could be given to private as well as public projects. He also recommended that "only a small percentage of funds" be earmarked for type three grants.

Hill-Burton Expansion (S. 2748 and H.R. 8149). Dr. Allman suggested that the Senate bill be amended to include a declaration of purpose similar to that in the House-passed measure, reaffirming that installations are for use of the entire community. He also called for a clarification of the relationship between priorities in the present act and those in the proposed measure, and for more specific definitions. He declared: "In particular the definition of 'diagnostic or treatment centers' is vague and ambiguous. It is not clear whether 'a diagnostic or treatment center' will include an individual physician's office, a group clinic, operated by physicians, or any hospital. How will the inventory be made by states under vague terminology of this type? We consider the language of this part of the bill to be an unwise amendment to an act which has been highly successful to date."

Vocational Rehabilitation (S. 2759). The bill would change the method of making grants to states in the interest of better administration. Dr. Allman told the committee that the Association "has not received a sufficiently clear explanation" to permit formation of a final opinion on the bill. He said AMA "has no position on the proposal at this time."

Reinsurance (S. 3114). Dr. Allman gave complete indorsement to the stated purpose of the bill, to promote the best possible medical care on reasonable terms. This, he said, has also been an objective of the AMA. Dr. Allman recounted progress of voluntary health insurance, then said he thought the future holds real promise for still greater progress. He concluded: "It is the belief of the American Medical Association that the bill will not fulfill its intended purpose and may, in fact, inhibit the satisfactory progress which is now being made by voluntary insurance companies."

Obstetrics in General Practice

LOUIS H. DOUGLASS, M.D.* AND D. FRANK KALTREIDER, M.D.†

Today the large majority of all births in urban and many in rural areas occur in hospitals and rightly so. Hospital deliveries are more convenient for both patient and physician and are certainly much safer. This trend is in some measure responsible for the very gratifying lowering of maternal mortality of recent years. Of more importance, however, is the attitude of the practicing physician who is always striving to do better and better work and to avail himself of advancements in medicine generally.

The very probable reason why so many men in general practice include obstetrics is because of a real liking for, and deep interest in, this branch of medicine. And it is certainly true that if this liking and interest exist, the physicians should continue to include obstetrics in their general practice. On the other hand, should it become an unpleasant burden, then, in fairness to himself and to his patients, the physician should cease to do obstetrics and should confine his work to those fields which are more pleasant for him.

For the physician in a general practice which does include obstetrics the general rules of the practice of medicine should apply, together with a few special ones.

First, it should be remembered that the process of reproduction is a normal, physiological function and, in the majority of instances proceeds most smoothly, when there is no ill advised interference. While keeping this in mind, it should also be realized that the dividing line between normal and pathological is a very fine one indeed; a line which may be crossed very easily and at times with startling abruptness. Therefore, there must be constant vigilance, early recognition of the slightest deviation from normal and prompt and proper treatment.

A long experience with maternal mortality

studies in the counties of Maryland has proven that almost without exception the physicians of our State are greatly interested in doing the best possible work. They have cooperated wonderfully in the study of those deaths which have occurred, they have accepted criticism most graciously and, most important of all, they seem to have profited by their mistakes. These men richly deserve all the acclaim and respect we can give them.

Also as a result of this same study a few deficiencies seem to stand out and these should be mentioned:

1—In a number of the reports of maternal deaths the physician stated that “The patient failed to cooperate and did not follow instructions.” Would it not have been nearer the truth to have said “The physician failed to cooperate and did not impress upon the patient the necessity of following instructions”? Most people are vitally interested in themselves and are willing to do what they are convinced is for their own good. But they have to be convinced first, convinced that the doctor is interested in them and that his instructions are important for the good of the patient. They must be concise, clearly understood and often the reason for them must be explained. What is meant may be illustrated by the following condensed case history, an actual case:

A multigravida, known hypertensive with cardiac involvement, reported to her physician for prenatal care at about the 24th week. Her blood pressure was 180/120 and the urine contained albumen. Patient was placed on a low salt diet and told to return in *three* weeks. She failed to report until six weeks had passed and her condition had worsened; she was given another appointment which she also failed to keep until another six weeks had passed. Advised to enter the hospital. Refused. Allowed to return to her home and not seen for four weeks when her husband called and stated patient was having convulsions. Admitted to the hospital but

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consultation was not requested until six hours after admission. Active and proper treatment now given. Too late. Patient died about twenty hours after arriving at hospital.

It should be evident to everyone that this patient should have been hospitalized at her first prenatal visit for evaluation and treatment. It is quite possible that 15 or 20 minutes spent in explaining to her the dangers involved and the necessity for a complete study would have convinced her and made her willing to "cooperate." When she failed to return upon the specified date, she should have been contacted at once and if she still refused to report the physician had 2 choices:

a—He could have gone to see her and

b—He could have retired from the case. One of these 2 courses should have been followed. As long as he continued to be responsible for the patient it was his duty to treat her properly, even though at a great deal of personal inconvenience. The remainder of this case history speaks for itself as an example of mismanagement.

2—Another frequent contributory factor to maternal mortality would appear to be an incomplete evaluation and treatment of some of the more common medical complications of pregnancy. A number of reports have been received of patients dying of heart disease complicated by a pregnancy and in almost every one of them it is evident that no attempt was made to evaluate the status of the heart early in pregnancy. The patient was seen too infrequently and little or no treatment was given until frank decompensation appeared. The same is true of many other complications.

3—Hesitancy in seeking consultation. Why this should be is difficult to understand. Is the general practitioner so much of a "lone wolf" that he feels competent to care for any emergency or complication? This is almost certainly not true. Does he hesitate to seek aid for fear his patient will lost confidence in him? If this be true he is jeopardizing the life of the patient for the sake of his pride and he also is working on a

false premise. Patients appreciate the doctor who is honest enough to admit his limitations and to seek help. Waiting until the patient's condition is desperate before obtaining consultation is a poor policy indeed.

With these exceptions, which are somewhat isolated instances, it would appear that the physician in general practice in Maryland is doing an excellent job in obstetrics. He must continue to realize his limitations and must be ready to seek advice and help when there occurs some deviation from normal.

The hospitals of the State must recognize their responsibility in this matter and must be in a position to grant privileges and also to vary the scope of these privileges to fit the ability of the individual physician. Consultation must be available and must not be too much of a financial burden upon the patient. Indeed in many instances, consultation will have to be furnished without remuneration.

It must be the duty of the medical school and the teaching hospital to teach and train the student and intern in the fundamentals of sound, conservative obstetrics and the early recognition of abnormalities and complications. The necessity of consultation must be stressed during this formative period and its advantages demonstrated.

Taking everything into consideration it is felt that obstetrical care in this State is on a very high level and is constantly improving. Naturally there is room for more improvement and it is doubtful that any of us will ever reach perfection. It would be unfortunate if we did for if there is no improvement to be attained, the incentive to work disappears and monotony and boredom occur.

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Topical Treatment of Dermatitis or Eczema

A REVIEW OF SIMPLE PRINCIPLES

H. HANFORD HOPKINS, M.D.*

Under the general classification of dermatitis or eczema there may be grouped more than one-half the Dermatological problems encountered by the physician. Regardless of the cause, whether external or internal, the condition is characterized by erythema, blistering to a greater or lesser degree, subsequent scaling or crusting, and itching. The general principles of topical treatment are more or less the same for the entire group. Since doctors in general are daily bombarded with samples of new salves, lotions, washes, soaps, detergents, pomades, etc., each supposed to be the "sine qua non" in its field, we often become confused, and forget basic treatment principles, often to the detriment of the individual patient.

Common examples of clinical dermatitis or eczema are Poison Ivy, Seborrhoea or Atopic Eczema in their many locations and forms, pruritus of the anus and vulva with associated eczematous changes, dermatitis or eczema of the hands and feet. Although Epidermaphytosis, (Athlete's Foot), is a fungus disease it presents the subjective and objective picture of dermatitis or eczema, and should be so treated, with specific modification indicated by specific etiology.

The first and cardinal principle of topical treatment for this group of diseases is to bring to the patient as much comfort and relief from suffering as possible, and at the same time *do him no harm*. This should mean disregarding the new and wonderful salve which came in the mail today, and sticking to the tried and known remedies of yesterday. It is very easy to make an eruption worse, and this is often inadvertently

done by the application of remedies which are new and relatively untried.

For purposes of topical treatment, all cases of dermatitis or eczema should be first classified in the mind of the attending physician as acute, sub-acute, or chronic. Let the acute category contain all patients who show swelling, redness, blistering, moist crusting and weeping. These are the acute "wet cases," and for them one specific set of rules of treatment should apply. Let the chronic category contain all cases who show little or no swelling, little redness, no blistering, but only thickening of the skin, scaling and cracking. These are the chronic, or "dry cases," and for them another set of rules should apply. Between the acute "wet cases" on the one extreme, and the chronic "dry cases" on the other, there exist all gradations between acuteness and chronicity, and this, of course, is the sub-acute category. It too has its special rules of treatment.

Although some patients first come to the doctor in the early phase of their eczema or dermatitis, others treat themselves with home or drug store remedies which may worsen the disease and occasionally cause it to become generalized due to a drug allergy. In most patients with dermatitis or eczema, the disease goes through all three phases, some slowly, and some rapidly. In each, one phase is dominant for a longer period of time than the others, and thus often becomes the presenting picture when the patient applies for help.

To consider the different principles of treatment for the acute, sub-acute and chronic categories of dermatitis or eczema Poison Ivy may be taken as an example. The patient with a severe attack of this disease usually begins with a

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typical acute or "wet phase," passes through a sub-acute phase, and recovers after a relatively short chronic or "dry phase." Plans of topical treatment which are applicable to the three phases of Poison Ivy Dermatitis are also in general applicable to the three phases in any dermatitis or eczema.

The acute or wet stage of Poison Ivy should have wet treatment. Wet treatment consists of the use of baths or compresses. The extent and distribution of the eruption determines whether one prescribes baths or compresses. For attacks involving a large part of the body surface, baths are preferable, and for those which are localized, compresses. The purpose of both forms of treatment is the same, namely to comfort the patient and keep him clean. Whether it be baths or compresses which are chosen, they should be used often enough, and long enough, to keep the patient as comfortable and clean as possible without the production of maceration of the skin from excessively prolonged wetness. The temperature of the bath or compress should be comfortably warm in winter, and pleasantly cool in summer. The simplest and safest bath for home use is the oatmeal bath. It is made by cooking one or more cups of oatmeal, placing the cooked oatmeal in a salt bag or cheese cloth bag, and swishing or squeezing the bag of oatmeal in the tub of water until the water is milky white. When the patient removes himself from such a bath he should pat and not rub the skin dry. Medicated baths should be avoided and left for the experts. Probably the best solution to use for compresses in the home is the saturated solution of boric acid. Physiological sodium chloride solution is very safe from the standpoint of being non-irritating but is more apt to allow the development of secondary bacterial infection. Boric acid solution should be made and used in large quantity. The ten quart water bucket, used in almost every home is ideal. The patient or nurse is instructed to dissolve ten level table-spoons of boric acid powder in the bucket full of

water. This is done most easily by making a soft paste of the measured powder with hot water in a cup and stirring the paste in the bucket of water until it is completely dissolved. Compresses should be bulky and applied sopping, but not dripping wet. They should be applied as a pack, and not wrapped around. An old soft Turkish towel is excellent. Compresses should be kept sopping wet by redipping them in the bucket of solution. They should not be allowed to dry in place because the boric acid crystallizes out and becomes irritating; and should not be remoistened by pouring on more, for the same reason. When compresses are removed, the affected parts should be allowed to dry in the open air if possible, and should not be bandaged.

When the acute, wet phase of the attack of Poison Ivy Dermatitis subsides into the drier, sub-acute stage, the use of wet treatment is gradually diminished in frequency and duration. The patient then needs interim treatment between the baths or compresses. For this purpose there is nothing better than powder either as such, or suspended in a liquid. The simplest and cheapest powder is cornstarch. It should be dusted on profusely between the baths or compresses. Calamine lotion, either with or without one percent phenol is still the safest lotion. Avoid lotions which contain antihistamines. They have no special virtue, sometimes sensitize the skin and produce dermatitis. Calamine lotion should be applied with the bare hand or a clean paint brush. Absorbent cotton or gauze should not be used since it removes the powder from the lotion. As the patient passes through the sub-acute phase the lesions become drier and drier, wet treatment is gradually minimized, and gives way to more and more powder dustings or applications of lotion. It is important not to begin the use of powder or lotion too soon since when applied to an exuding surface it forms an adherent cake which is uncomfortable, and under which infection may develop.

The chronic or end stage of Poison Ivy Derma-

titis is comparatively short. It is characterized by dryness, scaling, and desquamation, partly the result of the disease and partly the result of baths, compresses, lotions and powders. It demands only the use of a simple emollient, such as cold cream, vaseline, or light mineral oil until the skin has returned to normal.

Any case of dermatitis or eczema, acute, sub-acute, or chronic, can be safely treated by following the above rules. No patient will be made worse by such treatment. Many patients fully recover on just such simple measures. Expert advice should be sought for those who do not. If the physician will emphasize to the patient that most attacks of dermatitis or eczema are measured in weeks and not days, and that there are few short cuts in topical therapy, then fewer complications will arise as a result of injudicious therapy.

Certain precautions having to do with the use of wet, dry, and emollient treatment are necessary. It has already been pointed out that if baths or compresses are excessively used, maceration of the skin and even sloughing can result. This is especially apt to occur in intertriginous areas, notably between the toes, and the buttocks. Such opposing or enclosed skin surfaces should be carefully and completely dried after each bath or compress, before powder or lotion is applied. Oils, greases, and ointments should never be applied to the acute phase of dermatitis or eczema, except at times perhaps for the specific purpose of controlling or overcoming secondary infection. In general they increase discomfort, hold in the exudate and prolong recovery. Oils, greases and ointments furthermore are often badly tolerated on intertriginous areas. Applied between the folds of the buttocks, perineum, breasts and axillae, they often cause maceration, or a troublesome folliculitis. The use of soap and water is an important consideration in dermatitis or eczema. It is common practice to completely forbid the use of soap and water in all cases. Although this complete prohibition

is of benefit to some cases, notably dermatitis or eczema of the hands which often is caused in housewives largely by the excessive use of soap and water, it is unnecessary in many others. Soap and water is actually beneficial in some cases. Many cases of pruritus of the anus or vulva, with mild secondary or associated dermatitis or eczema, will improve or actually recover if the creases are washed carefully with a mild soap and water, dried thoroughly, and dusted with bland powder after each defecation.

In the treatment of the sub-acute and chronic eczemas and dermatitis, the number and variety of ointments available to the practitioner are almost endless. This is true also of the antiseptic, bactericidal, antibiotic, and antipruritic solutions. He would do well to avoid the use of all those preparations with whose effects he is not thoroughly familiar. When a chronic dermatitis or eczema does not respond to simple and well evaluated remedies of this type, he does well who then considers the condition a "noli me tangere," and calls for experienced help and counsel. It is well to remember that Calamine liniment (Calamine lotion in which olive oil has been emulsified), is an excellent and safe remedy for dermatitis or eczema in its uncomplicated sub-acute state, and similarly plain Lassar's paste is very useful and safe when applied thickly over an eczematized extremity and bandaged. Phenol should not be incorporated in paste or ointments which are covered with bandages because of the danger of systemic absorption and poisoning. In treating chronic eczema or dermatitis which is extremely itchy the practitioner often turns to stronger and more varied antipruritics, because of the rebelliousness of the problem, and thereby becomes confronted with an eruption which becomes worse instead of better. It is a problem easier to avoid than to combat after it has once developed. The simplest of remedies are usually the best except in the hands of the most experienced.

This review should not be construed as a diversion from the importance of definitive diagnosis in the individual case of dermatitis or eczema. Definitive diagnosis often spells the difference between success and failure in treat-

ment, but diagnosis does not lie within the province of this paper. The sole stress is upon general principles of topical treatment.

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MEDICAL STAFF NEEDED FOR SUMMER MONTHS

Camp Louise for girls and Camp Airy for boys, situated in the Blue Ridge Mountains of Maryland have vacancies for a medical staff. Third year medical students are acceptable. They can also place several nurses.

If interested call Miss Ida Sharogrodsky at the Baltimore office—641 North Eutaw Street, Saratoga 7-4828

PROCEDURE SET FOR DOCTOR DRAFT LOYALTY CASES

The AMA Washington Letter, No. 65

In anticipation of passage of the amendment to the Doctor Draft act, Defense Secretary Wilson has established a policy for handling all suspected loyalty cases arising under the act. (The amendment would permit the Armed Forces to retain, in noncommissioned status but assigned to professional duties, any physician, dentist, or veterinarian whose loyalty is questioned.) If the amendment is enacted, the following procedure immediately will become effective: (1) If questions of loyalty interfere with commissioning, an "intensive investigation" will be conducted; a 90-day limit is placed on the investigation, except in unusual cases, (2) if the man is found to be a security risk he will be "expeditiously processed out of service with an appropriate discharge," which will state that he was discharged *because his retention was not consistent with the security of the United States*, (3) if investigation clears the man, he will be offered a commission at the appropriate rank, (4) during the investigation, the individuals concerned will be "retained in an enlisted status and used in their professional capacity under necessary safeguards."

The proposed procedure was outlined by Assistant Defense Secretary Hannah before the Senate Armed Services Committee just before it reported out the Doctor Draft amendment.

Allergy in General Practice

JOHN W. PARSONS, M.D.

The manifestations of allergy constitute such a widespread and varied group of symptoms that every physician is likely to encounter some expression of the allergic state from time to time. It is variously estimated that ten to twenty-five per cent of our population have inherited the capacity to develop hypersensitivity to substances met in the environment, the so-called "atopic" reactions. There is no hereditary limitation on the ability to develop hypersensitivity to substances elaborated within the body, the "intrinsic" allergic states.

The latter category includes most of the sufferers from those allergic disorders which appear in the latter half of the life span, chiefly the asthmatic bronchitis and chronic urticaria appearing after the age of forty, and also many of the chronic cutaneous lesions of later life. A search for specific exciting factors is usually unavailing. This group of disorders is frequently associated with infections but in many cases no infectious process may be demonstrated, nor do presently known diagnostic methods give clear-cut evidence of the infective nature of the disorder. There is ample proof that concomitant infection leads to aggravation of the disease processes and control of infection is frequently followed by gratifying alleviation of symptoms. Emotional factors play an important part in this group of diseases, so much so that many cases of asthma, dermatitis, and other expressions of allergy are said to be wholly on the basis of emotional imbalance.

The atopic disorders usually appear at an earlier age, frequently are found to be associated with a positive family history of similar reactions, and are found to be caused by substances originating outside the body. The offending agent may be detected by history, by skin testing, or by challenging the patient with suspected offending materials. Thus, a history of respiratory symp-

toms occurring in August and September indicates probable ragweed pollen sensitivity; a history of frequent headaches or constipation may lead to disclosure of use of drugs to which sensitivity may have developed. Skin testing is of value in confirming facts of the history; it is particularly useful in detecting hypersensitivity to contributory factors and in determining the probable offending agents in those cases where the history is not revealing. The provocation of symptoms by feeding a suspected food, introducing a small amount of a suspected substance into the nose or conjunctival sac, or applying likely materials to the skin under adhesive patches is a useful means of determining the cause of allergic disorders. Infectious processes and emotional factors here, as in the case of the "intrinsic" allergic disorders, play an important contributory role in the aggravation and prolongation of symptoms. Either of these, together with physical agents such as chilling, overheating, or exposure to sunlight may act as triggers in initiating symptoms that had been in abeyance.

There is a common physiological mechanism in all the allergic states as indicated by the universal finding of edema (with concomitant muscle spasm in the bronchi and with eosinophilia) at the site of reaction be it in the skin, the respiratory mucosa, the conjunctiva, or the alimentary canal. Certain headaches are probably due to edema induced by a blood borne allergen. The edematous reaction is thought to be produced by liberation of histamine, or a similar substance, at the site of reaction between cell-bound antibody (reagin), and antigen (allergen), directly applied or blood borne. Many such reactions may be prevented by "antihistaminic" drugs which block the action of histamine. The topical or systemic application of epinephrine and other sympathomimetic drugs results in

reversal of this process. Further evidence of the unitarian nature of these disorders is their response to the adrenocortical hormones, whether administered in the form of the steroids or excited to production by the corticotropin of the pituitary.

Preventive treatment of the allergic disorders varies with the type and tissue involved. Where the offending substance is known, the patient may be able to avoid it; thus, the removal of a dog or cat from the home may result in complete relief of rhinitis or asthma, substitution of rubber foam for feather pillows will be helpful to the feather sensitive patient, and abstinence from foods proven to be offenders may make further treatment unnecessary. However, there are many individuals whose symptoms are produced by multiple factors, some of which, such as airborne pollens, house dust and fungus spores cannot practicably be excluded from the environment. Altering the patient's response to such factors by the hyposensitization (commonly spoken of as "desensitization") method will frequently result in gratifying control of the condition. Failure to obtain good response to the hyposensitization procedure is usually due to one or more of several factors such as insufficient dosage, failure to recognize and apply treatment against the full range of offending agents, persistent infectious processes, or unresolved emotional problems.

Treatment of the active symptoms calls for recognition of various physiological and anatomical derangements. Uncomplicated acute urticaria and its counterparts, allergic conjunctivitis and rhinitis, may be relieved promptly and suppressed indefinitely by use of antihistaminic drugs. These agents are, however, disappointing in the treatment of the more severe disorders such as asthma or atopic dermatoses. Epinephrine, 1:1000 aqueous, in doses of 0.3 Ml., subcutaneously, for immediate effect, and 1.0 Ml. of the 1:500 suspension in oil intramuscularly, for prolonged effect, is the basic remedial agent in these conditions. Applied

topically to the conjunctiva and nasal mucous membrane and by nebulization of the 1:100 solution for relief of asthma, this hormone has been of inestimable value. Ephedrine, for its convenience of oral administration, is less prompt and somewhat less effective than epinephrine. Synthetic drugs simulating these natural agents chemically and pharmacologically have value but, in general, are less effective.

Asthmatic breathing, usually thought of as an expression of allergy, may be produced by other mechanisms such as congestive failure, pulmonary fibrosis, tumors or bronchial infection. This state, whatever its etiology, is associated with bronchial obstruction in which muscle spasm, accumulation of tenacious secretion, and mucosal edema play a part. Aminophyllin and theophyllin preparations are of great value in relieving the spasm of the bronchiolar muscle. The intravenous or rectal administration of aminophyllin is usually demanded, as the dosage, 250 to 500 mgm., needed to produce a satisfactory effect is not well tolerated by mouth. Given in combination with ephedrine and a barbiturate, these drugs are of some value in oral doses up to 0.2 gm.

Potassium iodide is the most useful agent in bringing about liquefaction of the plugs of mucus which form in the small bronchi in asthmatic states. Usually well tolerated, it may be given in combination with antispasmodic and expectorant drugs. It must be noted that inspissated mucus in the bronchi cannot be liquified unless the general state of body hydration is satisfactory. Long continuing asthma may lead to pronounced dehydration. Other salts of iodine may be useful in this regard where the potassium salt is not well tolerated.

Bronchial infection, frequently associated with upper respiratory tract infection, is almost always found in asthma of long duration, and often it is the primary cause of disease. Chemo-therapeutic and antibiotic control of the infectious element, based, where practical, on cultural studies must be obtained in order to

attain relief of the symptoms. Broad spectrum antibiotics are, in the event that specific sensitivity tests are unobtainable, of great value in this regard. Eradication of suppurative foci is essential in order to obtain lasting relief.

Adrenocortical hormone therapy, soon to be described in considerable detail in this Journal, has opened a new and enormously effective therapeutic approach to treatment of the allergic disorders. The reader is referred to the report of the Baltimore City Medical Society panel discussion for details as to dosage and supervision of the effects of this type of therapy. It is noted that the cortical steroids, cortisone and hydrocortisone, through a little understood action, bring about a reversal of practically all the allergic phenomena. The response to infection on the other hand, an inflammatory reaction leading to repair by fibrosis, may be dangerously affected by the steroids through their depression of fibroblastosis. Thus, dissemination of infection may follow therapy intended to control an allergic state in which bacterial invasion had not been suspected. Such bacterial infection should, therefore, be sought before and during treatment with the hormones and, if found to exist, should be countered by the concurrent administration of antibacterial drugs such as sulfonamides or antibiotics as indicated by cultures and sensitivity tests.

Combined hormone and antibacterial therapy is usually indicated in asthma of long standing, the antibiotic or sulfonamide being discontinued when physical signs and laboratory procedures indicate eradication of the infection. In this connection, it is of interest to note that the fibrolytic property of the steroids is utilized to break down, in some degree, the protective barrier around an infective lesion in order to permit more intimate access of antibiotics to the site of bacterial growth. This mechanism is of considerable value in the treatment of nasal polyposis. It is, obviously, to be pursued only with strict supervision of the patient to guard against spread of infection. Activation of

quiescent tuberculous lesions has been observed in this type of therapy, an event fraught with danger but probably controllable with streptomycin in combination with other anti-tuberculous drugs. Perforation of peptic ulcer has occurred occasionally, making it imperative to administer antacid therapy along with the hormone where such a lesion may possibly exist. Demineralization of bone leading to osteoporosis of such degree as to result in collapse of vertebral bodies may come about in prolonged therapy. In this event, it is probably of no avail to feed supplementary calcium or Vitamin D.

Bearing in mind that cortisone, hydrocortisone and corticotropin (ACTH) serve only to suppress the functional manifestations of allergy, not, as is repeatedly stressed, to cure the allergic state, the physician is properly advised to administer these agents where other means have failed to bring relief to the patient. Prompt and persistent treatment may be lifesaving in status asthmaticus, severe drug reactions, and overwhelming infections with shock. Dosage must be in effective quantity, repeated as often as necessary to bring about and maintain control of the symptoms. Thus, in severe asthma intravenous administration of forty units of ACTH in a liter of five per cent glucose solution may be given in the first eight hours. Forty units of the ACTH gelatin suspension, intramuscularly, at twelve hour intervals may be used in less severe cases. Cortisone, two-to-three hundred milligrams, or hydrocortisone, one-to-two hundred milligrams, in divided doses daily will usually be sufficient to attain control of asthma, severe rhinitis, with or without polyposis, or the allergic dermatoses. Maximum dosage should be maintained until symptomatic relief is obtained, then gradually decreased to the minimum dose required to obtain prolonged effect. Self-limited disease states such as serum sickness, drug reactions, and pollen asthma need be treated only so long as the disorder would have lasted without therapy. Severe asthma may require lifetime treatment as with insulin for

diabetes. Other states, where the duration of symptoms may be of unpredictable duration, must be kept under control for estimated periods of weeks or months, therapy then decreased gradually, and resumed for a further period if symptoms recur. Rarely is it necessary to give more than seventy-five milligrams of cortisone daily (fifty of hydrocortisone) for maintenance of effect.

Gradual reduction in dosage when steroid therapy is to be discontinued cannot be stressed too emphatically. It must be remembered that replacement therapy of this type results in suppression of function of the adrenal cortex with more or less disuse atrophy of the gland. Abrupt cessation of treatment, even for symptoms of hyperadrenalism such as sodium and water retention, hyperglycemia and hypertension, may result in grave manifestations of adrenocortical insufficiency. In the need for surgery, even for the correction of such a therapeutic accident as

perforated ulcer, the dose of steroid should even be increased temporarily. Edema occurring during treatment may be controlled by rigid sodium restriction in the diet. Depression of potassium with its resultant weakness is to be countered by administration of a potassium salt, such as the chloride, at the rate of 0.6 gm. with meals. A few "pusher doses" of ACTH to hasten regeneration of cortical activity is advisable on cessation of steroids following prolonged therapy.

Failure to bring symptomatic relief of allergic disorders by means of some combination of the above mentioned remedies will sometimes occur and should stimulate still further search for contributory factors in this group of disorders which result in such a large part of human suffering.

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TAX DEDUCTIONS

AMA Washington Letter, No. 56

The House Ways and Means Committee voted to increase tax allowances for medical expenses by providing that medical costs can be deducted from taxable income if they exceed 3 instead of 5% of adjusted gross income.

Maximum limitations for deductions would be doubled from \$1250 to \$2500, multiplied by the number of exemptions, with a limitation of \$5000 on single taxpayers and \$10,000 for heads of families or married couples filing a joint return. These limits also double those in present law. The tax loss is estimated at about \$119,000,000.

Under the new proposal costs of medicines and drugs could be included in medical expenses only to the extent these items exceed \$50 or 1% of adjusted gross income, whichever is greater. At present it is generally accepted that all medicines and drugs can be included. The government expects by this change to add \$40,000,000 in tax money.

Transportation expenses, where travel is prescribed by a physician, could be deducted but not the cost of meals or lodging. A decedent's medical expenses also could be deducted if paid by his estate.

SYMPOSIUM ON THE COMPULSORY USE OF CHEMICAL TESTS FOR ALCOHOLIC INTOXICATION*

DR. RUSSELL S. FISHER, *Moderator*†

DR. FISHER: Ladies and gentlemen, I am delighted to welcome you to this symposium.

This is the Sixth Symposium sponsored by the Medico-Legal Committee of the Medical and Chirurgical Faculty of Maryland, the Bar Association of Baltimore City and the Maryland State Bar Association.

Tonight's subject is "The Compulsory Use of Chemical Tests for Alcohol Intoxication."

Our panel tonight will consist of Dr. Lewis P. Gundry, Dr. John C. Krantz and Mr. George D. Solter.

They will present their viewpoints on the subject, and then at the conclusion of their discussion there will be a question period, in which first the participants on the panel will exchange questions, and then they will be open to fire from the floor.

You have been provided with pencils and papers, and I suggest that you set down the questions that occur to you as the speakers talk, and then at the end of the presentation, we will gather them and present as many of them as time will allow.

Of course, the Moderator is supposed to introduce the speakers and then shut up, but, in the introduction of the subject of the use of chemical tests, I would like to make three points very briefly. First, I would like to point out that this is a current problem, and that alcoholism is an every-day problem in our courts, to our medical profession and to our legal profession.

To show some figures on the occurrence of this in automobile accidents and homicides, I would like to present very briefly some statistics on the subject.

Table I shows some of the figures in one of the recent years of the degree of alcoholism in victims of homicides in this City.

This is a group of some 68 people who died soon enough after they were assaulted that their alcohol determination would be significant. If you realize that only 21 of the 68 showed no

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† Chief Medical Examiner of the State of Maryland.

TABLE I
Alcoholism in Victims of Homicide

MANNER	TOTAL CASES	ALCOHOL CONCENTRATION—PERCENTAGE			
		None	.01-.09	.10-.40	.40+
Shooting.....	25	5	4	15	1
Stabbing.....	25	7	1	17	0
Blunt force.....	18	9	3	6	0
Total.....	68	21	8	38	1

TABLE II
Alcoholism in Highway Victims, 1950-1951—Baltimore

TYPE OF ACCIDENT	TOTAL CASES	ALCOHOL CONCENTRATION IN BLOOD OR BRAIN		
		Below .04%	0.05%-0.15%	0.15%+
Pedestrians.....	72	44	10	18
Drivers.....	52	20	13	19
Passengers.....	56	41	5	10
Total.....	180	105	28	47

alcohol, and that 39, or 57 per cent showed alcohol in concentrations which indicate that the decedents behavior was probably influenced by it, you realize that a large part of these cases which may be prosecuted as homicides are in fact caused or brought about by alcoholism.

To glance at Table II, which represents the alcohol levels of highway victims in the City of Baltimore over a two-year period, we find more or less the same thing; of the 180 persons who died promptly after the accident, 75, or more than 40 per cent, showed significant amounts of alcohol in their tissues, and the 47 cases who were above .15 per cent constitute 26 per cent of the total. In summary, a study of the people who die of violence of one sort or another, accidental or homicidal, shows that part of the problem, or part of the cause of their death is alcoholism.

Now, this is to be a discussion of the problem in Maryland, and a discussion of the application

of this to your every-day work, and so I would like to call your attention to the wording of Chapter 171 of Article 66½ of the Annotated Code of Maryland. This, of course, is the Motor Vehicle Section, and it refers to driving while under the influence of intoxicating liquor. It says, and I quote, "It shall be unlawful for any person who is an habitual user of narcotic drugs or any person who is under the influence of intoxicating liquor or narcotic drugs to drive or attempt to drive any vehicle, streetcar or trackless trolley within this State."

I think the significant part of that for the discussion tonight is that it states any person "under the influence."

And the definition of "under the influence" operates entirely in the way it is defined.

To get the definition of it, Black's Law Dictionary states this, "The expression is said to cover not only the well-known and easily recognized conditions and degrees of intoxication but any abnormal mental or physical condition which is the resulting of indulging to any degree in intoxicating liquors and which tends to deprive the driver of that clearness of intellect and control of himself which he would otherwise possess."

Now, this is a rigid definition. It says "to deprive the driver to any degree of that ability to operate a vehicle which he would ordinarily possess."

This is a more rigorous definition than perhaps attains in a place like California, where driving under the influence is interpreted, not in terms of impairment of one's own ability, but rather in terms, let us say, that one shall be adjudged to be under the influence when he impairs his ability to a point below that of an ordinarily cautious and prudent individual. In

that state the ordinarily cautious and prudent man must be anyone licensed to drive. So in interpreting "under the influence" under such a statute, a person is entitled legally to drive, even though he may have imbibed enough to lower his driving ability to the level of the worst driver licensed in the state. That leaves a lot of leeway.

The third question that I would like to raise is just how well are we handling our "driving while under the influence" cases in this State?

There was a recent survey made, and it may interest you a little bit to see some of the figures.

In Baltimore County, where there were 237 arrests last year, there were 144 convictions. That is 60.8 per cent.

In Baltimore City, where a vigorous effort is being made, it showed 64.3 per cent of convictions out of 639 arrests. Not much better. There are other communities, Frederick and Salisbury, where the percentage is 100 per cent, or very nearly so.

The lesson, I think, to be learned from the fact that the Courts convicted 60 to 64 per cent of those arrested and charged is, somewhere between two extremes. On the one hand, we are doing a very poor job of gathering, preserving, presenting and using evidence to indicate that an individual who is charged was, in fact, intoxicated, or we are unjustly charging a large number of people, and embarrassing them and costing them money and great effort to defend themselves against the charge which is unjustly made.

As I say, the truth lies between the two, but the way it is now, it is a very bad situation.

So much for the background of our discussion tonight.

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Our first speaker is Dr. Lewis P. Gundry.

Dr. Gundry received his A.B. at Johns Hopkins University, and his M.D. at the University of Maryland Medical School. He is at present Associate Professor of Medicine at the University of Maryland. He has been Secretary of the State Board of Medical Examiners for six years and since June of this year he has been President of the Board. He has a wide practice,

and he has a wide experience in the field of treating patients to whom alcoholism is a problem. He is going to present to us the physiology of alcoholism, and he will speak of such facts as the absorption of the chemical, the effects on personality of alcohol, and to some extent the ability to relate the effects of alcohol to its chemical content in the blood.

PHYSIOLOGY OF ALCOHOLISM

LEWIS P. GUNDRY, M.D.*

Dr. Fisher, Members of the panel, Ladies and Gentlemen:

I wish to discuss the action of alcohol, and the clinical significance of blood alcohol determinations in alcohol-influence or drunken-driving cases.

Ethyl alcohol has three principal actions. First, it acts as a local irritant; secondly, it is a food, or it has caloric value; thirdly, and most important, it is a depressant of the central nervous system.

It is this third action that we want to discuss principally this evening.

When an individual takes a drink of an alcoholic beverage, approximately 20 per cent of it is absorbed in the stomach, and 80 per cent in the intestines.

The rapidity with which alcohol is absorbed is increased if the person takes it on an empty stomach. Most of us have learned this at cocktail parties or on some other such occasion.

Rapidity of absorption is also increased if the alcohol is taken in concentrated form, such as straight whiskey, as contrasted to beer or wine.

If, on the other hand, an individual has taken a large meal, alcohol would be absorbed more slowly. This is particularly true if he has ingested fat, such as cream. Some people take cream before they go out, because they think they can give a better drinking performance in that way. It is true that alcohol is absorbed more slowly under such conditions; but, nonetheless,

it will catch up with you eventually, as we will try to show.

The concentration of alcohol in the blood reaches its maximum level in an hour and a half to two hours after ingestion, depending on the rapidity with which it is absorbed.

About 95 per cent of this alcohol is broken down or oxidized in the body, and only five per cent is eliminated by the kidneys and by the lungs.

However, there is a constant relationship between the amount of alcohol in the blood, in the urine, and in the expired air.

Alcohol is often erroneously considered a stimulant, particularly by the laity, an idea which is entirely wrong. This mistake is probably made because alcohol in small or moderate doses depresses the higher centers and removes the individual's inhibitions, causing him to be more talkative, more lively and in general more of an extrovert.

However, the real character of alcohol reveals itself as the individual continues to drink; he becomes drowsy, lethargic, and finally passes into a state of unconsciousness, or coma, which may result in death. Therefore it should always be borne in mind that alcohol is a depressant, rather than a stimulant.

I would like to discuss briefly the question of tolerance to alcohol. People who drink regularly and to a considerable extent, will develop an ability to oxidize alcohol more efficiently than the average individual. That is, they develop a tolerance for it. They can take more alcohol

*I am indebted to Dr. Russell Fisher, Dr. Howard M. Bubert, and Mr. G. C. A. Anderson for their advice in preparing this paper.

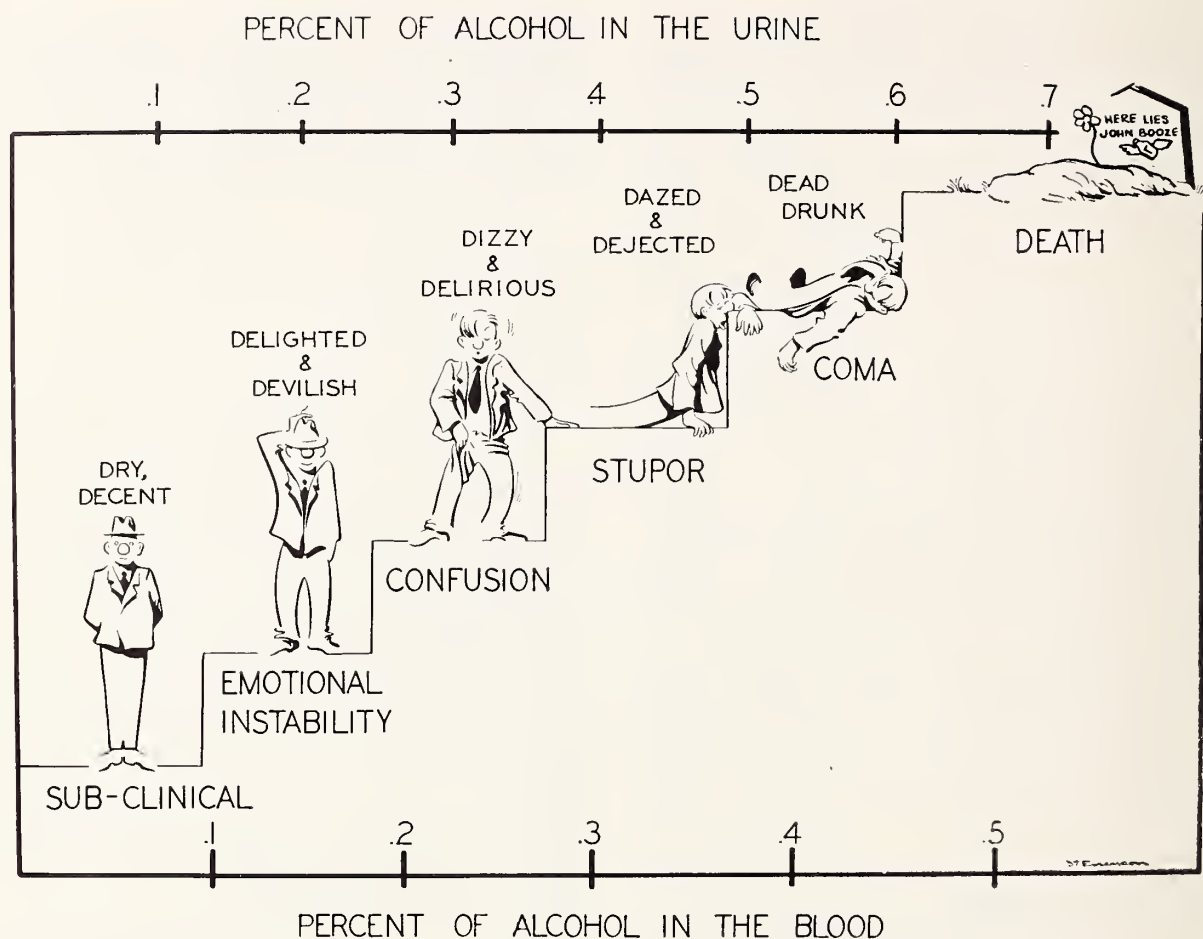


FIG. 1

without becoming intoxicated, and they seem to be able to imbibe better than the occasional drinker.

There are also those with poor tolerance who become maniacal, psychotic and unmanageable after one or two drinks. Fortunately these people are rare. Their condition is known as pathological intoxication.

It must also be borne in mind, in reference to the prolonged, heavy drinker, that after a number of years he will begin to lose his tolerance; after a certain period his tolerance declines and he may become intoxicated on only one or two drinks. This fact, I think, is important in relation to the subject we are discussing tonight.

Thus you see that capacity or tolerance will vary greatly in different individuals, or in the same individual under different conditions and at different times. The blood alcohol level,

however, can be correlated more accurately with the degree of intoxication or alcohol-influence.

Muehlberger¹ states that while there is a wide range of tolerance to alcohol which is swallowed, there is very little difference in the reaction of various individuals to a given level of alcohol circulating in the blood. In other words, all men with the same blood alcohol level are approximately equally intoxicated, within an error of plus or minus ten to fifteen per cent.

The blood alcohol level in terms of clinical intoxication is illustrated in Figure 1. As depicted, the individual with a blood alcohol level between zero and .1 per cent is described as "dry and decent," or subclinically intoxicated. However, as demonstrated in experimental work these people are not free from errors in driving automobiles, so that they are not quite as

innocuous and debonair as they might appear to the public.

The next level is .1% to .2%. In the middle of this group comes the zone of clinical intoxication. As given by most authorities on pharmacology it is .15%. The man is called delighted, and devilish. There are signs of emotional instability, decreased inhibitions, and slight muscular incoordination.

The next level which represents definite intoxication is .2% to .3%. He is "dizzy and delirious." He becomes confused, and reveals disturbances of sensation, decreased pain sense, staggering gait, and slurred speech.

At the level of .3% to .4%, he is very drunk. He is dejected, and has a marked decrease in response to stimuli, as well as muscular incoordination, with approaching paralysis, and complete unconsciousness.

Finally, between .4% to .5% (which has been given as a fatal level), he is in coma, with complete unconsciousness, subnormal temperature, and anesthesia.

And the last stage (.5% and above) is that level at which people frequently die. Figure 1 gives you an idea of the significance of various blood alcohol levels with corresponding percentages of alcohol in the urine.

It is important to remember that .15% is the level at which a person is definitely considered by most pharmacologists to be under the influence of alcohol, or intoxicated.

In the light of this data, let us consider the effects of various concentrations of blood alcohol on driving ability.

In a carefully controlled series of experiments Bjerver and Goldberg² tested 37 expert drivers. These men taught driving for a livelihood. They were at least theoretically, the best drivers obtainable for this experiment. These drivers were subjected to a series of driving tests. I won't go into detail, but very sketchily, there were five or six tests. The tests consisted of backing a car in and out of a garage; parking it; backing it onto a plank (getting two wheels on

the plank); going around a curve and knocking over obstacles on the left, and driving out of a sand pit.

The 37 drivers were divided into two groups: The first group we will call the control group; these drivers had no alcohol. They were tested, however, for alcohol, just to make sure that they had not slipped around the corner and obtained a drink beforehand. However, no alcohol was found in their blood. They did the above series of tests; waited two hours, and repeated the same tests. In the control group, there was an improvement of 20 per cent in driving ability on the second performance of the tests.

The second, or drinking group, was again divided into two classes: One class was given three or four bottles of beer over a period of ten or fifteen minutes, and the other class was given three or four ounces of whiskey, over a period of five or ten minutes (after they had done the tests the first time). About an hour or an hour and a half after they had been given the alcohol, they repeated the tests. The average blood alcohol level of those who had been drinking beer was .04%. That is less than a third of the level (.15%) for clinical intoxication. The average blood alcohol in those who had been drinking whiskey was slightly higher; it was .06%. In the two groups, it averaged .05%.

In those who had been drinking beer, there was a deterioration in driving. Instead of improving 20 per cent (as noted with the control group) they fell off 18.6 per cent. In those who were drinking whiskey, there was a decrease in driving ability and skill of 32.7 per cent.

Thus drivers who had ingested a relatively small amount of alcohol showed a very definite decrease in driving ability. This was found in all individuals; it varied slightly, but they all showed impairment of driving ability and judgment. As an example, one driver who tried the backing-up test attempted it thirty times without succeeding. He was still trying the same way at the end of the thirtieth time; this will give you an idea of what sort of driving he was doing.

This series of tests seems to me to offer conclusive proof that even a low level of alcohol in the blood definitely impairs driving ability. According to Sollmann's³ Text Book of Pharmacology, .15 per cent of alcohol in the blood is generally accepted—and I quote—“as the critical concentration for the chemical diagnosis of drunkenness,” or alcohol influence, if you prefer that term. Incidentally, to attain a level of .15 per cent, a person has to drink six or eight bottles of beer, or six or eight ounces of whiskey; twice the amount which was used in the above test.

The National Safety Council has reported that drivers with .15 per cent or more of alcohol in the blood have an accident rate of fifty-five times that of non-drinkers.

The National Safety Council and the American Medical Association have made recommendations for legislation which utilizes blood alcohol determinations. These recommendations are embodied in the statutes of Indiana, New York, Maine and Oregon (very similar in all these states), with the following three conditions:

1. With less than .05 per cent alcohol in the blood or equivalent amounts in other body fluids, the subject will be considered not under the influence of alcohol.

2. When there is .15 per cent or more alcohol in the blood or equivalent amounts in other body fluids, the subject is presumed to be under the influence of alcohol as far as the operation of a motor vehicle is concerned.

3. When there is between .05 and .15 per cent alcohol in the blood or equivalent amounts in other body fluids, there is a question of alcohol influence. In other words, the blood alcohol is considered along with clinical observations or other tests.

A very similar Bill (which was reported unfavorably) was brought up in the 1953 Maryland Legislature (H. B. 297). This Bill had exactly

the same three criteria for alcohol influence as the statutes of the four states of New York, Maine, Oregon and Indiana.

In other words, blood alcohol levels below 0.5% are not considered under the influence; above .15%, you are under the influence and not fit to drive a motor vehicle; and between .05% and .15%, it is questionable.

There was another paragraph in the Maryland Bill which I consider important. Paragraph 4 of this Bill reads, “The foregoing provisions shall not be construed as limiting the introduction of any other competent evidence bearing upon the question of whether or not the defendant was under the influence of intoxicating liquor.” Thus allowance was made for a clinical examination, and for any further evidence that a person might desire to produce in an individual case.

After careful thought about this matter, it is my considered opinion that we should have in Maryland some legislation which uses chemical tests to determine the degree of alcohol influence in drivers charged with motor vehicle violations. Let me hasten to add that I do not believe that the courts should decide any given case on the basis of chemical tests alone. They should utilize all other competent evidence bearing upon the question of whether or not the defendant was under the influence of intoxicating liquor.

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DR. FISHER: Thank you, Dr. Gundry.

DR. FISHER: Our second speaker of the evening is Dr. John C. Krantz, Jr.

Dr. Krantz is well known to most of you as Professor of Pharmacology at the University of Maryland Medical School. He has lived in Baltimore a long time and is well known in his field.

He trained first in pharmacy, and subsequently in pharmacology, at the University of Maryland. He has conducted research on anesthesia and on the problem with which we are concerned, the effects of alcohol.

He is well known as the co-author of a leading text book on pharmacology, entitled "Pharmacologic Principles of Medical Practice."

You perhaps know he is also the co-author of a book on public speaking.

Dr. Krantz will discuss the principles of analysis for alcohol in the blood, the urine and the breath, and he will have some further remarks on the interpretation of blood levels as they are met with in clinical practice.

Dr. Krantz.

THE PRINCIPLES OF ANALYSIS FOR ALCOHOL IN THE BLOOD, THE URINE, AND THE BREATH

JOHN C. KRANTZ, JR., PH.D.

Mr. Chairman, members of the Panel, members of the Bar Association, and members of the Medical and Chirurgical Faculty:

I do not believe there is any subject upon which there is more misinformation extant than that of alcohol.

It appears that an ardent prohibitionist, a well-meaning lady, was giving a demonstration one day to a group of children in school. She had a glass of water and a glass of alcohol. Into the glass of water she put several garden worms, and the worms remained viable. And then into the glass of alcohol she placed several garden worms. They immediately died. Then she looked around the class, and there was little Billy sitting down there, and she asked for an interpretation of that experiment. And Billy quickly answered and said, "Well, ma'am, that would indicate that if you have worms in the gastro-intestinal tract, you better take whiskey."

It has been pointed out that when alcohol is taken by mouth and ingested, it is rapidly absorbed from the gastro-intestinal tract. And this poses the very important question: Is alcohol normally in the blood of a person who has never imbibed alcohol? The answer to that question is yes. The food which we use for the body and which is our greatest source of energy is glucose— $C_6H_{12}O_6$ —and when glucose is broken down in the body into carbon dioxide and water, alcohol, C_2H_5OH , is also formed. If one examines the brain of anyone in this room at the present time,

the concentration of ethyl alcohol will be found to be 0.0004 per cent. That of the blood is 0.004 per cent.

What is more, in the pig, in the dog, in the bird, and in the chicken, one finds alcohol normally in the blood, owing to the fact that in the oxidation or the burning of sugar in the body, alcohol is an intermediate product.

Does this amount of alcohol produce symptoms of intoxication? Obviously not, or we would all be drunk at all times.

When alcohol is ingested by an individual it passes out of the gastro-intestinal tract into the general circulation. It is so uniformly and evenly distributed, that one might think of an individual as a sponge which has been dipped in alcohol, and absorbed the alcohol uniformly throughout. For example, if one sets the amount of alcohol in the brain at one, the amount in the blood will be 1.17, and the amount in the skeletal muscle will be 0.90, and the amount in the liver will be 0.91.

This is important, because of the fact that if one takes a sample of blood from an ear, or a sample of the urine, one can get a very good estimation of the amount of alcohol which is circulating through the brain, which is, in turn, the organ on which alcohol has its profound effect.

It has been pointed out by Dr. Gundry that when alcohol undergoes oxidation in the body, carbon dioxide and water are formed.

Let us ask ourselves this question: How about

the curve of alcohol disappearance from the blood? This is important from a medico-legal standpoint. Let us plot as ordinates on a curve concentrations of alcohol in the blood, as 0.05, 0.1 and 0.15 per cent. Also let us plot the times in minutes. Let us say 30, 60, and 90 minutes. Immediately, five minutes after the alcohol has been ingested, it is rapidly absorbed, and the curve of ascendancy in the blood goes up very rapidly. As it is oxidized, the curve of disappearance comes down slowly. The period of greatest intensity of symptoms in the individual is when this curve is on its ascendancy. For example, at one point, let us say that at .075 per cent, on the ascendancy curve, an individual will be far more under the influence of alcohol than if you consider him thirty minutes later, on the descendancy curve, even though the alcohol blood levels are the same.

The reason for that is perfectly apparent. As the cells of the central nervous system are being acclimatized to the presence of alcohol, it has the greatest effect. After the acclimatization has taken place there is a gradual wearing-off of the effect of the alcohol as it is metabolized.

Dr. Gundry has pointed out that alcohol is a food. If alcohol is a food, there are a few pertinent questions to ask about it. Is it a good food? Yes, it is a good food. Each gram of alcohol supplies seven calories of energy; a gram of carbohydrate, four; a gram of fat, nine; a gram of protein, four. Therefore alcohol is intermediate between carbohydrate and fat as a source of energy.

Is it a good source of food? No, it has to be burned immediately. We cannot store it in our liver and muscles as we can carbohydrate.

It is very interesting to note that when alcohol is burned in the body, the rate of burning of most individuals remains the same. If one takes the ideal man, of seventy kilograms, or 150 pounds, he can burn in the course of an hour about 12 cc. of alcohol.

How much whiskey is that? That is 24 cc. of whiskey—two thirds of an ounce of whiskey.

If he gets his alcohol at that rate, he very

seldom will ever exceed 0.04 per cent in his blood, and his symptomatology will be very low. The alcohol will serve mainly as a food and not as a drug.

The amounts of alcohol in the quantities that are found in the blood after the ingestion of large quantities of alcohol in the form of beverages can be estimated very accurately by chemical methods.

We know that in the human body alcohol is oxidized, and the products of metabolism are CO_2 and H_2O , identical with the products of metabolism of sugar.

Now, then, one may oxidize alcohol with chemical reagents. When one does this, by measuring the amount of reagent used by the alcohol, it is possible to tell how much alcohol is present in the blood, or in the organs, just as one can determine how much sugar is present in the blood.

Let us illustrate. There is an instrument known as the "drunkometer." The drunkometer depends upon the use of a chemical known as potassium permanganate. As most everyone knows, this is a chemical that is purple in color. This substance is an oxidizing agent. It will supply oxygen to the alcohol, converting it to carbon dioxide in water, and it will become colorless.

Now, for example, one may volatilize the alcohol out of the blood. By allowing the volatilized material, which is the alcohol, to come in contact with the potassium permanganate, a portion of the permanganate is decolorized. But one has found through very careful examination of many people who drink alcohol that some of it is eliminated in the exhaled air. The amount depends on the amount of alcohol in the blood. That relationship is this: The amount of alcohol in the blood is two thousand times that amount of alcohol in the exhaled air.

Let us think about that a moment. Why should it be so little in the exhaled air? Well, 95 per cent of alcohol is metabolized, and about 3 per cent is excreted in the urine, and about 2 per cent is excreted in the exhaled air. Therefore,

the relationship, which incidentally is a rather constant one, between the amount of alcohol in the exhaled air and the amount of alcohol in the blood is a reliable one.

Another device which is used for the determination of alcohol in the exhaled air is the "Alcometer."

The principle is essentially the same. A material known as iodine pentoxide supplies oxygen to the alcohol and converts it to carbon dioxide and water. The iodine reacts with a starch paste and sets up a blue color, the intensity of the blue color is picked by a photo-electric cell. From these data one can definitely determine the amount of alcohol in the exhaled air. This when multiplied again by our factor of two thousand gives the amount in the blood.

One might ask the question, are these tests infallible? No. No chemical test is infallible. And the question can be asked, does one have to be very careful about conducting them? Yes, one has to be extremely careful, extraordinarily careful, but yet in the hands of a skilled technician, the test works out very well.

When the drunkometer was first developed, they used it to find out the condition of the operators of motor vehicles in and about the City of Chicago. They got a laboratory test truck to go out on the roads with men dressed in white. Drivers were stopped and addressed in a very polite way, "Would you let me have a sample of your exhaled air" Few objected. They were rather proud to blow a sample of their breath into the container with the colored solution of potassium permanganate. When no decolorization occurs one was told to get back into the car, "You have no alcohol present in your blood."

One of the first steps was directed toward determining when the drinking would take place. They found that of those driving at noontime only about two per cent had been drinking. But between twelve Saturday night and two A.M. on Sunday, one finds that this goes up about twenty-five per cent. So then you ask the question, well who are these people? The

age peak falls between twenty-five and thirty, with equal distribution between the sexes. In other words, there are as many women as men drinking between the ages of twenty-five and thirty years and operating a motor vehicle while under the influence of alcohol.

Dr. Gundry and I discussed the tests that were carried out in the Caroline Institute in Stockholm, Sweden, which he so excellently delineated for you.

I would like to make one or two other comments with regard to these tests.

Those individuals, who were expert drivers, were shown to have an impairment of their driving ability under the influence of alcohol, and under the influence to the extent of about 0.04 per cent. These same individuals were subjected to the so-called flicker fusion test, which determines the acuity of one's vision to watch a flicker of light fuse into one light as the intensity of the light is increased. These people under the influence of alcohol deteriorated thirty-seven per cent in the flicker fusion test.

Again, they tried these people with the so-called "blink test." In this test there is a jet of air which is directed against the cornea. The degree of pressure which is required for the individual to cause blinking is determined.

These drivers again deteriorated to the extent of thirty-three per cent in their performance after they had alcohol in their blood to the extent of 0.04 to 0.056 per cent.

It seems to me that the evidence is quite clear that: One, we know where the alcohol goes in the body; two, we know by chemical means that the amount of alcohol that can be determined with a fair degree of reliability; and three, we are nearly certain that the symptomatology, the measurement of one's acuity of vision, of hearing, and so forth, parallels the alcohol concentration in the blood of those individuals who ingest it.

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DR. FISHER: Thank you, Dr. Krantz.

DR. FISHER: I believe that the medical men have now established for us the background, insofar as the scientific part of the alcohol test is concerned. And we now are going to turn to the other portion of this, which is the application of the test to the problems that face us in court every day.

To cover this phase of the subject, Mr. George D. Solter has been asked to address you.

Mr. Solter received his schooling here in Baltimore. He received his A.B. at Johns Hopkins University, and his LL.B. at the University of Maryland.

He was for a while engaged in the private practice of law

in Baltimore, and more recently, for some three years, has been associated with the State's Attorney's Office in this City.

Mr. Solter was the first State's Attorney to be assigned to the Traffic Courts last year, when it became evident that the real assistance of the State's attorneys was needed in the handling of drunken driving cases. He served for quite some months there, and I assure you he can talk from his experience.

I believe he is going to restrict himself to the legal questions, and the questions whether this is proper evidence, and what is apt to happen with such evidence here in Maryland.

Mr. Solter.

APPLICATION OF THE TEST TO THE LEGAL PROBLEMS

GEORGE D. SOLTER, ESQ.

Dr. Fisher and fellow members of the Panel, members of the Committee, and ladies and gentlemen:

As Dr. Fisher has just told you, I have been asked to give the lawyer's approach to this problem, and although I am at present and have been in the Prosecutor's Office, I will attempt to make my remarks applicable to both sides of the problem, that is, from the defense lawyer's standpoint and the standpoint of the Prosecutor.

Of course, everything I say is based upon the assumption that everything these gentlemen have said is scientifically and medically correct. If what they have said is not, then anything I say on the subject is of little help, because we have to rely upon the accuracy of their studies, and the studies of those who work with them in other states in the same field.

In recent years, the public has become increasingly aware of the menace of the driver of an automobile who is under the influence of liquor, or, as he is commonly known, the drunken driver. Fourteen states have already placed upon their statute books new laws which finally put teeth into the law making it a crime to operate an automobile while under the influence of alcohol. These new laws have led to the introduction in the courts of the various chemical tests for alcoholic intoxication, which have just been described to you. In some states, the tests are compulsory. In others, the results of the

tests are made admissible in evidence, if voluntarily given by the suspect. And in still others, the term "under the influence" is merely defined in terms of the tests in the event that a test was made and offered and accepted in evidence at a trial.

In 1952, the peak of public attention to the problem was reached here in Baltimore after a tragic fatal accident and the trial of the driver involved, who was charged with "operating under the influence." As a result of this, an Assistant State's Attorney was assigned to the Traffic Court by agreement of the State's Attorney of Baltimore and the Chief Magistrate of the Traffic Court, to prosecute all "under the influence" cases.

Now, I might say right there that the reason for that coming about is that a Traffic Court is a less formal court than the courts of the Supreme Bench of Baltimore City, and the Circuit Courts of the Counties, and there is a tremendous volume of traffic offenses handled there every day.

Under the normal situation, the police officer appears as the prosecuting witness and presents his own case. The Magistrate hears the evidence, and the defendant tells his story. Of course, if there are other witnesses for either side, they are brought in to testify.

It became apparent that these operating "under the influence cases" were serious matters. In almost every case the defendant was repre-

sented by counsel, and the Magistrate was placed in a dual capacity of being the prosecutor as well as the sitting judge. This placed a very heavy burden on the police officer, who had to present his own case.

In recognition of these factors, the triangle was completed by placing the prosecutor there to present the State's evidence, and to relieve the Magistrate of the dual function of having to try to direct the testimony out of the State's witnesses, and then in fact sit in judgment on the case.

Although this change helped the situation immeasurably, it was obvious that the law was not definitive on the question and must be changed in order to give the courts a scientific standard to help measure the term "under the influence," in addition to the other competent evidence to be presented.

In recognition of this need, House Bill 297 was introduced in the Maryland Legislature last year, but, unfortunately, and contrary to what my brother here said about the progress of the Bill, my information is that it died in committee, and never got out at all.

This Bill was, in the words of those who opposed the use of tests generally, the least obnoxious, in that it merely established certain presumptions, should a chemical analysis of the defendant's blood, urine, breath or other bodily substance be introduced in evidence. The three presumptions were as follows:

1. If the percentage was .05 or less, he is presumed not to be under the influence of intoxicating liquor.
2. If the percentage was in excess of .05 but less than .15, no presumption arises, but the presence of alcohol in the blood may be considered in determining guilt or innocence.
3. If the percentage was in excess of .15, he is presumed to be "under the influence," but that, of course, is a rebuttable presumption.

The law made it clear that the test was not to be the sole measure, and its use was not to limit the introduction of other competent

evidence bearing on the question of whether or not the defendant was under the influence.

Since this Bill never became law, today we are still faced with the same problem in court, and many dangerous drivers are acquitted, to return to their automobiles, perhaps to kill or maim; and occasionally an innocent person may be convicted. Perhaps at the next session of the Legislature, the Bill or a similar one, may pass, but until it does, the courts must continue to face the vague, biased, inaccurate and inconclusive evidence often placed before them by the witnesses.

To illustrate what I mean here are some typical bits of testimony that you will obtain in these cases.

You may have testimony to the effect, that at the scene of the accident one of the motorists is very irate and aggressive, and he protests to everyone, and when the police arrive he says, "Arrest that man, he is drunk."

The officer then goes about his investigation, and he may or may not feel the same way that the motorist does, but anyway, on the basis of that complaint, he places a charge of "operating under the influence" against this individual.

Well, a lot of things can happen between the time of the accident and the time that this case comes up in court.

One thing that can happen is that the irate motorist gets a nice check from the insurance company, or from the other party, for his damages, so that when he gets into court, the pressure is off, and he is satisfied, and under examination he will say, "Well, I am not sure, I did smell alcohol, but I could not be positive that he actually was under the influence." And so your testimony begins to fall apart.

Then you have the case where the motorist comes through with flying colors, backs up his statement that he has made at the scene, and so testifies in court. However, the officer may come in and say, "Well, I could not say that this man was actually under the influence from what I observed about him."

Thus you have a conflict in the State's evidence right there, raising a rather serious question of doubt in the mind of the Magistrate, and there is nothing else for him to do but to throw the case out.

Then you have the injury alibi situation, where you establish your case all right, where everybody says the operator appeared to be well "under the influence" from all external things, such as slurred speech, staggering, bleary-eyed, and the odor, but the defendant then takes the stand and he says, "Well, there was an impact, my head bumped against the steering wheel, and I don't know, I don't remember too much about what happened." Of course, there is no physical evidence on the man that he was injured, but there you are. You don't know what to do with a thing like that.

These are just some of the things that we run up against in trying these cases strictly on the physical evidence that can be gathered from the people at the scene.

To point up the essential need for and the value of chemical tests of alcoholic intoxication, let me summarize a recent case in a state which had compulsory tests. There was an accident between two automobiles; one a sport model driven by a youngster, the other an expensive sedan operated by an elderly, well-dressed man. The youth staggered from his car, and the odor of alcohol was obvious from several feet away. His speech was slurred, and at times unintelligible. From the crowd which had gathered came words such as, "He sure is plastered—hope he gets what is coming to him."

Then the other driver calmly surveyed the situation and with steady gait, approached the police who had arrived at the scene. The youth was unable to give his address, state where he was or the day of the week, but he steadfastly denied that he had had anything to drink. He was given the balloon test, one of these breathing tests which have just been discussed. The older man, who admitted a drink or two

several hours earlier, but who had no odor of alcohol on his breath, was given the balloon test also, "Just for the record."

Well, as a result of these tests, the older gentleman was later tried and convicted of operating "under the influence," and the boy was sent immediately to the hospital for observation and was found to have a concussion. Much to the amazement of all witnesses, and the police, the tests showed no alcohol present in the boy's blood and .25 per cent in the older man's blood. The strong odor of alcohol on the youth was found to have come from a broken radiator and anti-freeze which had sprayed on his clothes at the time of the accident.

Can anyone doubt that the result of this case would have been the reverse if these tests had not been available and used? Perhaps a life as well as a reputation may have been saved.

Perhaps the most tenuous problem, from the lawyer's standpoint, will arise out of the question of the admissibility of the results of a chemical test where the test has been made compulsory by law. This problem can be broken down into two questions:

1. Does the taking of a sample of blood, breath, urine or other body substance for the test violate the constitutional right of the individual to refuse to testify against himself?

2. What expert testimony should be required to introduce the results of the test as competent evidence?

Dealing first with the question of constitutionality, we should examine the Maryland law and the cases that touch upon the point. There are two recent Maryland cases which may help us draw certain conclusions, but I do not feel that either settles the law, or would be controlling if applied to compulsory chemical tests for alcoholic intoxication. In *Shanks vs. State*, in 185 Maryland Reports, at page 437, decided in 1945, the Court of Appeals held that a test of blood found on the coat of the accused, who was charged with rape, was admissible against him, when this test was used for comparison with other tests of blood from the victim of the

assault, blood from an alibi witness, and blood found at the scene of the crime. The Court distinguished this case from another in which it was held to be error to force an accused at his trial to try on a hat, which had been found at the scene of the crime. In that case, while the defendant was in court, in the progress of the trial before the jury, the State attempted, over the objection of the defendant, to place a hat that had been found at the scene of the crime on his head, to see whether it fit or not, and the Court allowed it, but the Court of Appeals reversed the Lower Court and said that this was forcing a man to incriminate himself. The Court had this to say:

"The difference is, . . . that when such comparisons and experiments are made outside of court, the evidence falls from the lips of witnesses other than the defendant. The production of such evidence, therefore, and the testimony thereto, is not that of the defendant but of other witnesses, while on the other hand, if the defendant is required against his objection in open court, in the presence of the jury, to make such experiments and comparisons, no extraneous evidence is required and the constitutional prohibition is thereby violated."

It must be noted, however, that this case dealt with blood from the coat of the accused and not with a sample of his own blood taken from him. It, therefore, seems to be open to question as any precedent in the problem we are discussing.

The other case, which seems to me is a strong authority for the constitutionality of the compulsory tests, is *Davis vs. State*, 189 Maryland Reports, at page 640, decided in 1948. In this case a murder suspect had taken a quantity of iodine in an apparent attempt to take his own life. After treatment, he was placed in a cell in the County jail and treated by the County Medical Officer. The following day he was visited by another doctor, who took a specimen of the defendant's blood. The doctor said nothing of his reasons for taking the blood,

except that it was at the request of the State's Attorney.

At the trial of the suspect, the results of a test made on this specimen of blood were introduced over objection of the defense, along with the results of tests of blood from the murder weapon, from clothing of the deceased, and from clothing of the accused, to show a comparison of the blood groups found. On appeal, the defense contended the blood from the defendant was taken from him by a subterfuge, and, therefore, violated his constitutional immunity to testify against himself. The alleged subterfuge was based on the defendant's belief that the specimen was being taken for use in connection with his own treatment for iodine poisoning, and, therefore, was not given with his consent for the purpose for which it was used at his trial.

In this case, the Court held, after stating that the question should be viewed as if the evidence had not been obtained by the completely voluntary action of the accused, that the case was one which fell into the class of cases where physical evidence had been obtained before trial and had been offered against him at the trial. In affirming the action of the trial court, the Court of Appeals said:

"We are unable to see where there is any constitutional question involved in this case. There is no substantial difference between obtaining a specimen of blood from an accused and obtaining his finger prints, or any other physical property, the possession of which by him is a pertinent question at issue in a felony charge against him. . . ."

Now, for you lawyers who are present, it is perfectly true that this case involved the commission of a felony, whereas "operating under the influence" is made a misdemeanor. It would seem to follow, however, that if the blood test was admissible in a homicide case, which is a felony by common law, and involves the possible death penalty, it would be admissible in misdemeanor cases, where far less threat to life and property of the accused is present, even

though the Maryland law does draw some distinctions between the admissibility of evidence in felony and misdemeanor cases.

That is a rather broad principle, which we do not need to go into here tonight, and which I am not going to go into. But for the purpose of this discussion I feel it would make no difference, and I feel definitely that the Courts would rule that since "operating under the influence" is a misdemeanor, and a lower grade of crime, that they would follow the other case, where they allowed this to come in as a felony.

The argument of those who oppose the use of compulsory chemical tests, on the basis of unconstitutionality, centers on the theory that although the evidence or specimen has all the characteristics of physical evidence, it is still in the nature of something coming from within the accused himself and is, therefore, comparable to words of an incriminating nature either spoken or written by him.

Thus it seems to me that although the question is still not completely answered, the Davis case, which I have just discussed, appears to be a strong authority for the constitutionality of compulsory tests in Maryland. If you are interested in any further discussion on that point in other jurisdictions, where the authorities are divided, reference is made to 164 American Law Reports, from page 952 through page 967.

Now, as to the question of expert testimony, some aspects of which have been dealt with by Dr. Krantz, the usual rules of evidence as to experts would prevail. The party offering the expert must show the qualifications of the expert as to training in the field, experience and general knowledge of the subject matter. His opinion concerning the results of the tests is admissible once he is qualified and once the proper foundation has been laid for the introduction of the results of the test. By the latter, I mean that the party offering the results of the test must show the conditions under which the test was made, prove that the chemicals

were compounded to the proper percentage for use in the testing instrument, and prove the custody of the specimens from the time of taking to the time of calculation or analysis of the chemicals, showing thereby that the specimen was, in fact, taken from the accused and that it was not altered or otherwise changed between the sampling and the calculation.

Now, that is the burden that rests upon the State to even offer the tests at all before it gets the expert to tell what the tests mean.

As a practical matter, it is my opinion that once the practice of using the tests becomes general, the expert testimony itself will be replaced by a written report of the expert, providing the foundation for the introduction of the test results can be satisfactorily laid. Such is the case today in most homicide trials where counsel usually agree to submit the autopsy finding, without requiring the doctor to be present and testify as to the fact and accuracy of the autopsy itself.

Of course, we have lots of cases where we call Dr. Fisher and his colleagues in, where the question is in dispute, of whether or not the wound could be caused by the alleged murder weapon and where the actual cause of death is in dispute. The defense counsel usually want him present, to see if they can break him down. They are not very successful.

There are many other facets to the whole question, which are too numerous to discuss at length. Most of these will resolve themselves after a determination of the constitutionality issue. I am referring to the need of advising the accused that the information derived from the tests may be used against him in court, the admissibility of the fact that an accused refused to submit to the test, and finally the validity of a penalty imposed by law on an accused who refused to submit to the test. There are some states that have that provision.

Obviously, if compulsory tests are held to be constitutional, then these other questions become moot, but if the compulsory feature of

the law is not sanctioned, then it would seem that the introduction of the results of a test might be subject to some of the same requirements of evidence which now surround the introduction of an incriminating statement of an accused in any criminal proceeding.

Thus, after a review of the factors giving rise to a need for compulsory chemical tests of alcoholic intoxication, and of the law of Maryland and other jurisdictions on the question of admissibility of the results of such tests, it would seem to me, from the lawyer's standpoint, that a law based on the scientific approach, as given by Dr. Krantz, is highly desirable and would accomplish the following objectives which are important to all of us.

1. The elimination of guesswork from the prosecution of driving "under the influence" cases.
2. The removal of the drunken driver from our streets and highways.
3. The protection of the occasional drinker, who may be competent to drive, but victimized by the circumstances surrounding an accident in which he may be involved.
4. The giving of prompt medical attention to persons who may be injured and at the time

show the physical manifestations of alcoholic intoxication.

I think we are all seriously and sincerely dedicated to these objectives, not only those in the law enforcement field, but all concerned. Even defense counsel, who appear in Traffic Court frequently representing clients charged with this offense, should welcome it, because in many cases it will let their man out right off the bat, without any trouble at all, if he does not have enough on board to meet the requirement.

I want to thank the Committee for asking me and giving me this opportunity to make a few remarks on this subject, because I feel it is a vital one, and I think that public interest in it may help us the next time we get a crack at the Legislature to do something about it. I thank you very much.

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DR. FISHER: Thank you, Mr. Solter.

May we take just a minute now and ask a couple of the folks in the front row if they will go back and pick up any questions that may have been written. And may I ask you to pick them up and present them to Mr. Stanley, over on the side, who will organize them for presentation while we are asking other members of the panel some questions that have already been presented for our study tonight.

QUESTION PERIOD

DR. FISHER: Among the questions that are immediately proposed is the following one, which is directed to Dr. Krantz.

Q. What illnesses, injuries or other conditions of an individual can produce the outward appearance and symptoms of intoxication without any significant amount of alcohol being present in the system?

DR. KRANTZ: Insulin shock may produce a syndrome comparable to alcoholic inebriety.

What is more important, one finds that febrile conditions can produce disorientation of an individual. Certain types of pneumonia may do this. The administration of many drugs will

produce a syndrome comparable to the condition of inebriety. For example, the antihistamines can produce drowsiness, and inability to think quickly and alertly, with diminution of acuity of vision, and hearing. We find that such old-fashioned drugs as paraldehyde or chloral hydrate may produce a syndrome comparable to alcoholic inebriety. And we find that such drugs as atropine, when given in toxic doses, will produce hallucinations, disorientation and amnesia, which is again a syndrome comparable to alcoholic inebriety.

DR. FISHER: Thank you, Dr. Krantz.

It appears that a good many medical condi-

tions may confuse a physician, and it may be that too many questions may produce the same effect. But I hope not.

Q. Here is a question directed to Dr. Gundry: Does an old toper absorb alcohol as fast as an uninitiated individual?

DR. GUNDRY: I think I may have partially answered that in my brief talk, but, as a general rule, when he is at the peak of his prowess as a drinker, he probably absorbs alcohol faster than the average or uninitiated drinker. However, after he passes the peak and begins to deteriorate, he does not absorb it as well. As I mentioned, he may develop high levels of blood alcohol with a relatively small amount of alcohol ingested.

Q. Could we follow that up a little bit more? This old toper who absorbs alcohol rapidly, just where does he stand in respect to the fellow who drinks a quart a day, and yet who never appears drunk? How can he keep up with that situation, when you or I go out and have seven highballs and are not eligible to drive an automobile? What is the difference? Is there a difference of ability to tolerate the alcohol, or is it an ability to burn up the alcohol, so that we do not get a high level? This is an important question, Dr. Gundry.

DR. GUNDRY: That is a pretty hard question to answer. However, I will stick to what I said, that I believe that two or three individuals, regardless of their experience and their ability to drink, if you find them with the same blood alcohol, they will be about equally incompetent to operate a motor vehicle.

DR. FISHER: I think that is an important question that repeatedly occurs to those of us concerned with the problem.

Mr. Solter, I have one for you.

Q. How does the law which utilizes blood alcohol tests work out in the fourteen states where they now have such a law? Can we learn now about some of the points in Maryland, in comparison with the other states?

MR. SOLTER: I am not going to answer that

question on the basis of constitutionality, but rather on the basis of practicality.

From the literature that I have read on the subject, where these tests have been used in many other states, the most significant thing reached is that the conviction rate is up around 90 per cent or better.

Now, there are a lot of reasons for that.

I think one significant reason is that by the use of the test at the scene, and a rapid calculation made, many people are never even charged, because the result of the test would indicate to the authorities that the person was not sufficiently under the influence to warrant even the issuing of a ticket. So that you eliminate that group right at the source.

And then jumping to the other extreme, where you get a test that shows a high percentage, you get a high level of guilty pleas. And so that helps a great deal. You save a lot of time, and it makes it easy for the Magistrate. I think the statistics do show that a far more effective enforcement situation exists where they do have the tests.

DR. FISHER: Thank you.

Here is a question which seems to be directed to me.

Q. Of what particular value is such a test when there are different degrees of alertness by the driving public? In other words, one person who may be alert and intelligent, even when under the influence of alcohol, would still be more alert than some dull-minded person who has never touched a drop of alcohol.

This, to be answered, involves saying simply that under the law of our State, "under the influence" is defined in terms of significant impairment of one's own ability to operate a motor vehicle. In other words, it is the presumption that each citizen has certain duties to the general public to maintain himself in his best driving capacity. And even though there may be a few dull drivers, who are very poor drivers, and who may even go around killing people, that does not allow the rest of us who

are good drivers to get ourselves so tanked up that we become as big a danger as those very poor drivers.

Here is another question, one which I think one of the panel might answer. It gets down to the question of percentage.

Q. What does the alcohol present in the blood of an individual represent in relation to the amount of alcohol actually consumed by the individual?

This has been touched upon, but I think it might be repeated, because it is the current belief that one can take a drink and still be a safe driver.

DR. KRANTZ: Dr. Gundry has touched on this problem this evening, but I want to give you certain percentages of alcohol that have resulted in the blood of individuals who have ingested definite quantities of alcohol.

Miles, in England, some ten or fifteen years ago, took a number of individuals and gave them 34 c.c. of absolute alcohol. That would be 100 proof. And we find that this alcohol was diluted to 100 c.c. and that in turn would be comparable to a 34 per cent alcoholic beverage. A weak whiskey, in other words. And the individuals who took this had an average concentration of alcohol in their blood of 40 milligrams per cent, and on the other hand, when this same amount of alcohol was diluted to a thousand c.c. it was 34 milligrams per cent instead of 44 milligrams per cent—the concentration in the blood was far less.

There is another point that I would like to emphasize with regard to drinking, and the amount of alcohol in the blood.

This experiment has been repeated many times.

If you take a non-initiated individual with this amount of alcohol, let us say 34 c.c., diluted to a hundred c.c.—that is roughly three ounces of a 34 per cent alcohol—the non-initiated individual, the occasional drinker, will have about that concentration in the blood. However, if you give it to an old toper, you will find that

his concentration in the blood will be far less. It may be half as much.

The reason for this is that repetitious drinking, and the repetitious impinging of particles of alcohol (the constituents of the drink) upon the mucosa of the stomach and intestines, causes it to become indurated, and the alcohol is not absorbed as rapidly.

And this is a condition that is called a pseudo tolerance, not a real tolerance.

But this is the result of the constant effects of the alcohol that he is taking. He is getting the pleasure of drinking, if you can call it pleasure. But he is paying for it. He does not really get much of the effect, but he is simply taking pleasure in drinking it and taking it down the hatch.

DR. FISHER: Here is a question for Dr. Gundry.

Q. Does alcohol increase the physical efficiency of an individual when taken in small calculated amounts?

DR. GUNDRY: No, it does not. I am sorry, but it does not.

All tests that have been done with accuracy, like throwing darts, or playing baseball, or doing anything that requires ordinary physical coordination, even playing tennis, is not done as well when under the influence of alcohol.

People commonly think that they are doing better, because their inhibitions are removed, and they move around with seeming great facility. However, they do not do the tests better.

This has been my observation over many years in treating chronic alcoholic addicts and watching them play pool. You know about how he plays on the average, and then you see him miss two or three easy shots. You wonder what his blood alcohol is. Very often, when checked, it is found to be rather high at that time.

Now, there is another question here. Do you want me to answer that?

DR. FISHER: Yes, go ahead.

Q. DR. GUNDRY: What effect does fatigue have on a person with alcohol in his system?

Well, I think it has about the same effect as on a person without alcohol.

This was observed in the experiments of Bjerber and Goldberg, in which two groups of drivers were exposed to exactly the same amount of fatigue, or boredom, or whatever factor entered, and I think it was shown that the effect was about the same. Very often when you hear a person say that he is tired, I think that it should be spelled differently. Instead of t-i-r-e-d, it ought to be t-i-g-h-t.

DR. FISHER: Here is a question for Mr. Solter.

Q. Do you believe a blood test taken from an unconscious defendant would be admissible in court?

MR. SOLTER: Well, there are cases in other jurisdictions which have held on that question both ways.

That may sound like typical lawyer's answer, but in law you can always find a case somewhere that is opposed to what you want.

It would seem to me that if the test were upheld on the question of self-incrimination, that is, if it could be taken from him when he is aware of what is going on, without violating his constitutional rights, that certainly it would be equally constitutional to do it when he was without his senses. I don't know whether that satisfactorily answers the question or not. But, on the other hand, I think that if it were not constitutional to take it from him while he was aware of it, obviously it would not be the other way.

DR. FISHER: Dr. Krantz, here is one for you.

Q. Would a high blood sugar give a false positive blood alcohol or a higher blood alcohol percentage in the iodine pentoxide starch test?

DR. KRANTZ: No, it would not.

DR. FISHER: That disposes of that.

Here is another one for Dr. Krantz.

Q. If the percentage of alcohol when ingested is known, and the base line time element at the base of your graph, would it not be necessary to know exactly when the driver began to drink his six beers, and to know how long he lingered

at the bar to drink from his first to his sixth beer; and also would you not have to know the time of the accident when the test would be given, and how much time elapsed after the accident before the test was given?

This is a double question, actually, the first having to do with whether you can prophesy a blood level in terms of time spent in drinking it; and the second, what is the effect of delay after the accident on the picture of the individual at the time he had the accident.

DR. KRANTZ: No, you cannot prophesy a blood level in any individual from the amount of alcohol he has ingested, because so many factors are involved.

As has been pointed out this evening, one important factor is how much food is in the stomach during the time of ingestion. This will delay the absorption.

If the alcohol has been ingested in malt beverages, such as beer, or ale, the colloidal matter will retard absorption of the alcohol. The dilution of the alcohol is an important factor. And what is more, every individual will absorb alcohol to a different degree. The absorption of alcohol from the gastro-intestinal tract is absorption very much like through a sieve. It is like a small particle going through a larger opening. And the absorption of certain other materials, like sugar, from the tract is a more definitely regulated process and it involves certain enzymatic reactions. So that the amount of alcohol cannot be predicted in one's blood from the amount of alcohol that has been ingested, unless all the other factors are known. And then it would be nothing more than a speculation, and not an accurate estimation.

Q. DR. FISHER: In other words, it is not so much to know how much he drank or when he drank it, but you would have to go back to some test to show what his blood level was at the time of the accident?

DR. KRANTZ: That would be my opinion.

Q. DR. FISHER: Now, the other part of this question goes into the delay between the accident

and the time the test is taken. And this is an important problem in the use of the test. Can you tell us something about that?

DR. KRANTZ: Well, the test, of course, will give you no indication as to when the alcohol was ingested. It will not tell you whether the curve was on its ascendancy or whether it was on its descendancy, which in turn may make a difference in the symptomatology of the patient. Nevertheless, the test will tell you that he has or has not alcohol in his blood, that will influence the alacrity in his ability to handle various situations.

DR. FISHER: Here is one for Mr. Solter.

Q. The license to drive being a privilege granted by the State, could it not be made a prerequisite in his application to get a driving permit that he agrees in advance that if he is ever accused of drunken driving in the future, he will submit to a chemical test?

MR. SOLTER: I have a feeling I know who thought up that one.

MR. WOLFSON: I have the answer to it.

MR. SOLTER: Of course, that goes back into this whole question that the license to drive an automobile is a privilege granted by the State rather than a right that exists in the individual as a citizen.

It would seem to me that under the present interpretation of licensing, that that condition would be valid, because now, today, even if a man is convicted in the Traffic Court, where the Magistrate has a right to suspend a driver's license up to ninety days for the conviction, the individual is still subject to administrative review of his case by the Commissioner of Motor Vehicles.

And it frequently happens, that even after a man has been sentenced, fined, and his license revoked or suspended, or, rather suspended by the Traffic Court, for the maximum ninety days, he may go before the Commissioner on a hearing and have his license taken up permanently, indefinitely, or for a specific period of time.

So that points up the issue, that it is still looked upon as a privilege rather than a right of the individual.

If it were a right, a lawyer might have a good argument when he went before the Commissioner of Motor Vehicles to claim that his client was being placed in double jeopardy, that he had already been tried and convicted for this offense at the Traffic Court, and his sentence had been meted out, and that any further action would place him in double jeopardy.

Lots of people have argued that, but nobody has ever taken it to the Court of Appeals. And I am not the Court of Appeals, and I do not know what the answer is.

MR. WOLFSON: Well, Mr. Solter, I asked that question.

Now, isn't it true that in civil cases all non-resident drivers in effect subject themselves to having service of summons received for them—and whether they ever get them or not makes no difference—but you send the notice of summons, advising the disposition of the license with respect to the non-resident driver.

MR. SOLTER: That is right.

MR. WOLFSON: Now, they are subject to judgment even if they never come into court, and that procedure is followed even when the registered letter is mailed out.

MR. SOLTER: That is right.

MR. WOLFSON: To follow out along that line, it seems to me that applicants for drivers' licenses could be required by the State, under its Police power, as a condition precedent to the issuance of the license, to agree to submit to an alcohol test if ever requested to do so by proper authority, on the theory that a license to drive is a privilege and not a right.

MR. SOLTER: Well, I think that is a very good analogy.

DR. FISHER: Here is a question that I know there is no answer to. But it has been directed to Dr. Gundry, and I will ask him if he has anything to say on it.

Q. How can one organize a club among doctors entitled "Never Drive Having Drunk?"

DR. GUNDRY: As Dr. Fisher has already pointed out, there is not a simple answer to that question.

Most of the legal profession I am sure know it is very difficult to get more than one or two doctors to agree on a diagnosis.

Doctors are rather rugged individualists. However, I can say for myself, after reading all this literature I am impressed to the point that I will not want to drive when I have had more than one drink. You never know exactly how it is going to affect you. It may be absorbed rapidly, or slowly. Personally I have no desire to get involved in alcohol influence cases, and especially with somebody like the gentleman over here on my right acting as prosecutor.

DR. FISHER: Here is one that has reference to the fact that our Maryland statutes provide for driving while under the influence of intoxicants as well as under the influence of drugs.

I acknowledge that briefly by saying that is true. Yet the problem of driving while under the influence of drugs is almost negligible, in comparison with those persons who drive while under the influence of alcohol.

DR. FISHER: Here is one directed to Dr. Krantz, again getting down to where the chemical test is employed.

This is the doctor's question.

Q. Will the presence of hydroxy butyric acid (as a part of acidosis)—alter the final result in a breathing test?

DR. KRANTZ: I cannot answer that question out of my own experience, except that my opinion would be that the amount of hydroxy butyric acid present on one's breath would not influence the test with regard to the amount of alcohol that is present. This is due to the fact that if alcohol had been ingested, the amount of alcohol would be so much greater than the amount of hydroxy butyric acid that the amount

of hydroxy butyric acid would be negligible as influencing the test, if it did, and I am not sure that it would.

DR. FISHER: This has been confirmed many times, even diabetics of the worst type, taking the chemical test, will show a result of .01 or .02, and we know that we would not accuse them of drunken driving.

DR. FISHER: Here is one that could probably be put to all of you:

Q. Would it be in order for this meeting to pass a resolution endorsing the use of alcoholic tests in drunken driving cases, and send such results to the proper authorities?

Now, I don't know how to answer that question. I am sure that it is in order for every one in here, both the physicians and the lawyers, and the other folks concerned, to work, and to work actively, at the Legislative Council level, and, more importantly, in Annapolis, when the opportunity arises to do something that will improve the way we are handling our drunken driving cases.

We know of some of the things that have happened in the way of handling these "under the influence cases" in other places. And by a vigorous program of enforcement, they can show statistically that they have decreased deaths due to alcoholism.

In the City of Detroit, in a period of less than ten years, they have shown a decrease from ninety a year to ten a year.

If Detroit can do that, Maryland can do something good along this line.

And whether this Act provides for this meeting here to pass a resolution, I do not know, but I am sure it is certainly proper for those of us here who are interested enough to come in here for such a discussion as this to continue to work for improvement in our problems along this line.

I think this rounds out the questions. And if there are no more, I believe the meeting should stand adjourned.

ARTICLES OF INTEREST

PRESENTATION OF THE SCHERING AWARD TO IRVIN P. POLLACK

A sophomore medical student at the University of Maryland School of Medicine received a check for \$500 as first prize winner of the 1953 Schering Award. Mr. J. Roger Cox, the mid-Atlantic supervisor of this firm, presented the award to Mr. Irvin P. Pollack, and Dr. H. Boyd Wylie, Dean of the Medical School, participated in the ceremony.

Mr. Pollack wrote on the "New Concepts in the Treatment of Peptic Ulcer." He is a graduate of the Baltimore City College and The Johns Hopkins University.



Mr. J. Roger Cox, Mr. Irvin P. Pollack and Dr. H. Boyd Wylie

REPORT OF THE JOINT COMMITTEE ON DISEASES OF THE CHEST

At the request of Dr. Webster H. Brown and Dr. Otto C. Brantigan, State Officers of the American College of Radiology and the American College of Chest Physicians, the following report is published so that all our members may be familiar with it:

PURPOSE OF JOINT COMMITTEE ON DISEASES OF THE CHEST

In establishing a Joint Committee on Diseases of the Chest, the purpose of the American College of Chest Physicians and

the American College of Radiology is to exchange ideas and to propose guiding principles on the problems involved in routine chest x-rays in hospitals (general, mental, etc.), and mass chest x-ray programs. The committee agrees: that each physician should be encouraged to have a chest x-ray on all of his patients; that every patient admitted to a hospital, private or public, should have a routine chest x-ray; and that the follow-up for all suspected lesions seen in chest x-ray surveys should be organized very carefully to assure that the patient comes under medical supervision.

LIMITS OF SURVEY

Routine chest x-ray examinations should be defined as those examinations of the chest which are conducted to screen persons with abnormal changes of the chest from persons with normal chests. The examinations are screening diagnostic procedures and are not to be considered as clinical diagnostic examinations. The screening method is for the purpose of detecting the presence or absence of a lesion only.

The size of the film which one uses for screening purposes is not of primary importance. The committee believes in principle, however, that when microfilms have been used, a 14" x 17" film is a necessary second step in the screening procedure and the mechanism whereby such is provided in any community shall be determined by the local medical society or the local hospital staff. Survey chest x-rays either in hospitals or in the general population are approved as a screening device if conducted by agencies which utilize well qualified professional and technical personnel and which make sincere efforts to send the positive individuals to qualified local physicians or clinics for proper follow-up.

INTERPRETATION AND REPORT

Interpretation and reporting of medical findings is a medical matter and should bear the signature or identification of the responsible physician.

METHOD OF REPORTING

Method of reporting of chest survey studies: This is a local matter and is by prearranged agreement between the employer and the employee in industrial surveys; in other surveys is in accord with medical ethics, according to local agreement.

TYPE OF REPORTING

Type of reporting: The committee discourages the reporting of suspicious cases as tuberculosis. It believes this to be a clinical diagnosis. The x-ray interpreter should designate the cases that require immediate follow-up as "urgent." The small film x-ray interpretation is merely an impression.

It should be emphasized that the 14" x 17" film is a diagnostic aid and the results derived therefrom are also impressions and not diagnoses. Even the larger film is but one of

several examinations necessary in order to establish correct diagnoses.

DOUBLE READING

The committee notes the several publications indicating the extent of false negative and false positive reports resulting from inter- and intra-individual variations in interpretations of chest films. From these it is evident that failures to detect tuberculosis can be reduced by multiple readings, but at the expense of increasing the false positives, unless a check mechanism is employed. The simplest elaboration of multiple reading is the independent interpretation of the film by two physicians with referee conference of the two undertaken in those cases in which they disagree. Only those cases on which both agree in conference should be followed.

While such a procedure may result in the detection of a slightly larger portion of all the abnormal cases, it may not be feasible from an economic or personnel standpoint. Groups responsible for survey operations are urged by the committee to give consideration to double reading as one of the methods by which survey yields may be increased. Availability of financial resources and qualified professional personnel, as well as the need for other services of relative importance, will be determinates in this decision. The committee, therefore, calls attention to some of the virtues of double reading but does not recommend it unreservedly.

PROFESSIONAL COMPENSATION

The professional cost of performing routine chest examinations in hospitals: The Joint Committee believes the radiologist and/or chest physician should be compensated just as any other physician practicing his profession. The procedure is time consuming and places a definite responsibility on the radiologist or chest physician. The committee likewise felt that in this matter the basic principle of payment is by arrangement between the physician and the hospital or agency involved. In the reading of follow-up films there should also be an individual limit to the number of films which should be read in any one day by one physician and which he should not exceed. The compensation, of course, would have to take into consideration whether the physician makes the film in addition to interpreting it.

CLOTHING OF PATIENTS

Whether or not a screening examination can be conducted with the patient fully clothed: Since the number of lesions overlooked because of clothing (2%) is considerably smaller than the normal variations of interpretation demonstrated to exist in the reading of photofluorographic films, it is concluded that the examination of clothed persons is as effective a procedure as examination of the undressed persons. Since examination of the fully clothed persons is an easier procedure as compared

with the examination of the undressed persons, the committee agreed that screening examination may be conducted with the patient fully clothed.

READERS' QUALIFICATIONS

Qualifications of readers in mass chest surveys: It was believed at the present time there was no practical method which could be used to evaluate the qualifications of a particular reader. Studies in this respect are being made at the present time. It is hoped that within a short period of time satisfactory testing methods will be available. The committee therefore agreed to leave this matter open for further discussion.

PROTECTION

The radiation received by all professional, technical and clerical personnel associated with photofluorographic equipment should be continuously monitored by means of film badges or other devices which have been proved to be satisfactory for determining the radiation exposure of personnel.

When an individual receives more than 100 milliroentgens per week, the medical officer in charge of the unit should immediately determine whether the individual has been careless or whether the protective devices of the equipment are at fault.

If the fault lies with the individual, the individual should be informed of the fact and strongly cautioned regarding the dangers of excessive radiation exposure. Failure to regard such warning should be considered as negligence on the part of the individual.

If the fault lies with the equipment or protective devices, the photofluorographic unit should immediately be taken out of commission until such time that measurements of radiation conditions where technical or clerical personnel are required to work will yield radiation exposures less than 100 milliroentgens per week for case loads of 2500 exposures at 95 kv. and 40 ma. seconds (the average exposure per photofluorographic chest film).

CONTINUATION OF STUDY

It is recommended that the Joint Committee arrangement continue and that the Joint Committee meet annually, or at the call of the co-chairmen. In an effort to have the Joint Committee act continuously and without interruption, interim ideas should be sent to the co-chairmen, and an exchange of opinion should continue during the intervals between meetings. Recommendations are solicited from all interested in the affairs of the Joint Committee.

Respectfully submitted,
LEO G. RIGLER, M.D.
OTTO L. BETTAG, M.D.
*Co-Chairmen, Joint Committee
on Diseases of the Chest*

Component Medical Societies

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

As this goes to press the State Meeting is ending. It has been a splendid meeting. The instructions to the City Delegates concerning the Building Fund Assessment were kept. The sentiments of the meeting were such that passage of the resolution seemed assured in any event. Palms to Doctor Goldstein.

The City Society Constitution changes our regular Meeting date to the FIRST Friday in each month. (It has been the third Friday). We were all aware of this when the Constitution was read and passed. It was not until the program for the State Medical Meeting put it in print that the reality of the change of custom was realized by many. The new program date: FIRST Friday, should be kept in mind.

The General Practice Section of the City Society is having an organization meeting in May. Copy for this issue goes in too soon to hazard any predictions about what will occur. This Section organization is in accord with developments all along the line.

The Executive *Committee* differs from the Executive *Board*, whose membership is as stated in the new Constitution. The Committee consists of the *elected* officers of our Society and passes on matters that have to do with the actual business of running it. The Executive *Committee* is meeting about every two weeks now, and considers a large number of matters that are brought before it, and it screens applications for membership and carries out the voted mandates of meetings. The Executive *Board* meets on the third Tuesday of each month and is concerned more prominently with policy formulation and matters of inter-society as well as intra-society importance.

BALTIMORE COUNTY MEDICAL ASSOCIATION

SAMUEL P. SCALIA, M.D.

Journal Representative

The Sheppard Pratt Hospital in Towson was the scene of the April luncheon meeting of the Balti-

more County Medical Association. The meeting was held Wednesday, April 21, 1954.

Dr. S. P. Scalia gave a report on the recent meeting of JOURNAL Representatives held at the Faculty Building. The Society welcomed the opportunity of devoting one issue of the JOURNAL to Baltimore County. We have promises of several scientific articles, but are anxious to accept more. The JOURNAL is especially interested in some historical material concerning Baltimore County and the medical society. If any readers have any such materials, please contact the writer. Pictures are particularly desirable.

Quite a discussion was raised by the proposed yearly registration of all Maryland physicians as suggested by the JOURNAL Representatives group. It seems that there is no current roster of active physicians in the State of Maryland. The Narcotics Bureau and the County Clerk cannot disclose their listings. Therefore, no one knows what the physician census of Maryland is. This problem is to be discussed at the House of Delegates meeting.

The scientific portion of the program was presented by Dr. Raymond Band, a member of the resident house staff. He read a paper entitled, "Recovery from an Acute Psychosis Following a Coronary Thrombosis." The paper was well received by the membership present.

CARROLL COUNTY MEDICAL SOCIETY

WILLIAM L. STEWART, M.D.

Journal Representative

At a recent meeting a committee consisting of Drs. Foutz, Bare, and Jennette was appointed to determine whether or not an emergency medical call system is needed in Carroll County.

Dr. Werbner recently associated with the Springfield State Hospital at Sykesville was welcomed into the Society.

Our guest speaker was Dr. John Young, a former Carroll Countian, who is now practicing urology in Baltimore. Dr. Young gave us a very interesting talk on hematuria and its causes, frequency in the

female and its frequent cure by repeated urethral dilations, and the relation of enuresis in children to congenital anomalies. His lecture was made even more enlightening by the x-rays he brought along showing the various conditions of which he spoke.

DORCHESTER COUNTY MEDICAL SOCIETY

ALFRED R. MARYANOV, M.D.

Journal Representative

Four years ago, the members of the Dorchester County Medical Society voted to have all monthly meetings at the homes of the various members, proceeding alphabetically down our roster. This has worked quite successfully, and all of the meetings have been very well attended. At the present time all of our monthly meetings are attended by better than ninety per cent of the members of this Society.

The March meeting of this society was held at the home of Dr. Walter B. Johnson on March 18, 1954. The speaker for the evening was Dr. Eugene Traub, Professor of Dermatology of New York Medical College. His topic was Common Dermatoses, which was illustrated by lantern slides. Dr. Traub maintains his home in the vicinity of Cambridge, and is present in this community from Thursday to Monday. The local members of our Society have made use of Dr. Traub's knowledge of his specialty, and at the present time Dr. Traub conducts a Dermatology Clinic at the Cambridge Maryland Hospital once monthly.

HARFORD COUNTY MEDICAL SOCIETY

FREDERICK J. HATEM, M.D.

Journal Representative

The March meeting was held at Dr. Horky's home, and buffet luncheon was served. Dr. Frank Ayd of Baltimore spoke on "Physical Methods in Psychiatry," and described the present status of shock therapy, lobotomy, and treatment with new drugs.

Members present were: Doctors Barthel, Brendel, Dolce, Dorogi, Finney, Hall, Hatem, Hodous, Horky, Marek, Palmer, Phillips, Rodman, Sandeck, and Stonesifer.

Old business:

Woman's Auxiliary—meeting to be arranged with representatives of Baltimore City group and some local wives.

New business:

1. Faculty building assessment. The delegate, Dr. Rodman, to attend discussion uninstructed.

2. Adoption law. Dr. Horky to attend meeting. Harford County Medical Society considers law needs revision.

3. Secretary-Treasurer—Dr. Hatem elected to replace Dr. Hayman who resigned to accept position of Assistant Director of Public Health of the Territory of Alaska.

WASHINGTON COUNTY MEDICAL SOCIETY

SIDNEY NOVENSTEIN, M.D.

Journal Representative

The Spring meeting of the Medical Society of Washington County was held at the Alexander Hotel April 15th, 1954 at 6:00 p.m., Dr. Archie R. Cohen presiding. The following was the agenda:

SCIENTIFIC SPEAKERS

Public Relations

Mr. Robert L. Richards, Staff Secretary of the Committee of Public Relations of the Medical Society of the State of Pennsylvania and Dr. Allen W. Cowley, Chairman of the Committee of Public Relations of the Medical Society of the State of Pennsylvania spoke of the need for more public relations and it was emphasized that a good Public Relations Program should consist of six (6) points:

1. Provide an adequate emergency call service.
2. Create a grievance or mediation committee.
3. Maintain a speakers' bureau supplemented by other health education activities.
4. Establish good working relations with the press, radio, television and other publicity media.
5. Build leadership among society members in county or area with all voluntary and governmental health organizations.
6. Prepare and use all available means to actively encourage every family to secure the services of a family physician.



Courtesy of The Hagerstown Daily Mail

Standing, from left to right: Dr. Ernest Poole, Dr. Archie R. Cohen, Dr. B. B. Kneisley, Dr. L. Stephen Noel, and Dr. S. Earl Young. Seated left to right: Dr. Allen W. Cowley and Mr. Robert L. Richards.

GUESTS

Guests of the Medical Society were Washington County Dental Society and members of the Board of Trustees of the Washington County Hospital.

EXHIBITS

Various local companies presented exhibits of modern business procedures and techniques.

BUSINESS

The delegate to the annual meeting of the Medical and Chirurgical Faculty was instructed to approve the following resolutions:

1. To assess members of the State Society on the following basis (Baltimore City members \$150.00; County members \$100.00, payable

over the next ten years), in order to raise funds for the new faculty building.

2. Proposed changes in the Constitution.

It was announced that the invitation of the Washington County Medical Society to the Medical and Chirurgical Faculty was accepted and therefore the semiannual meeting of the State Society will be held in Hagerstown in the fall of 1954.

Report by Dr. O. D. Sprecher, Chairman of the Committee to investigate feasibility of Washington County Medical Society taking charge of one issue of the JOURNAL was given and the Committee felt that it would be impossible to do so because of the lack of material, therefore the Society vetoed any such undertaking.

WOULD YOU LIKE AN INTERESTING PAMPHLET?

"Medical Research May Save Your Life!"

This pamphlet tells the dramatic story of what medical research and medical care have meant to all Americans. The price is 25¢ per copy, but if bought in quantity are less expensive. If you wish a pamphlet or additional information write to Lura Street Jackson, Public Affairs Pamphlets, 22 East 38th Street, New York 16, New York.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

HYPERTENSION

LOUIS KRAUSE, M.D.*

"Man is as old as his arteries" was said by the ancients, particularly in the pre-Christian era in Greece. Today, we know very little more about arteries than those folks did at that time. We still are stressing a physical finding and rarely do we relate it to an etiological cause. Save for the few reversible surgical conditions causing hypertension, the isolated instance of psychosomatic hypertension, the minority helped by diet, our remedies are far from satisfactory. Perhaps we are in a comparable position in this century as the doctors were in the last century in regard to fever. Conditions were called intermittent fever, continuous fever, remittent fever, etc, etiology entirely unknown. At this time we are calling hypertension frequently according to its rapidity of development, the height of it and whether it is fluctuating, benign and malignant, etc.

To cover the story of vascular diseases and hypertension is impossible, but to get a bird's eye view of the theories and the many remedies offered, one needs just to glance over the following list. It is apparent immediately that where the fundamental truths are unknown, theories multiply.

The following books on "Hypertension" may be borrowed from the Library:

- Allen, F. M. Treatment of kidney diseases and high blood pressure. Morristown, Physiatrie Institute, 1925.
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* Chairman, Library Committee.

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SUMMARY OF LIBRARY ACTIVITIES IN 1953

The attached statistical report falls far short of giving a true picture of the library activities. The new staff were too busy trying to familiarize themselves with the library and serving patrons to record the statistics.

With the resignation of Mrs. Eleanor Kohler, effective September 30th, and the coming of Miss Myrtle Hollins in her place, the entire library staff with the exception of Mrs. Ella Chatt, janitress and stack assistant, was new since November 1, 1952. Unfamiliarity with what had gone before has been a great handicap.

Some highlights of the year in the library follow.

1. SERVICES.

a. Reference work (much of it by telephone)

Supplying names, addresses, etc. of doctors from our directories.

Verifying references, including long bibliographies.

Compiling bibliographies.

Looking up material on hundreds of such varied subjects as hyperthyroid disease and pregnancy, prolapsed placenta, spontaneous pneumothorax, lymphosarcoma of nose or paranasal sinuses, technique of sympathectomy and of subtotal adrenalectomy for hypertension, parathyroid tumors in superior mediastinum, articles written by some 30 staff members of Spring Grove Hospital during their tenure there, history of various county medical societies, etc., etc.

Locating specific articles, with very little information to go on.

Assembling information and material for the exhibit on "300 years of Maryland Medicine" held at the Maryland Historical Society.

b. Getting out material for use in the library or for home use; checking the latter in and out, and replacing material on shelves.

c. Mailing material to members throughout the state.

d. Behind the scenes preparation of material, which includes checking against card catalog or periodical record for duplication, accessioning, classifying and cataloging, plating, stamping, marking, etc.

e. Borrowing from and lending to other libraries.

f. Distributing duplicate books and journals to younger libraries in the city, and to other libraries throughout the world through the Medical Library Association Exchange.

g. Contributing book lists and library notes for each issue of the Maryland State Medical Journal, and compiling indexes to the 1952 and 1953 volumes of the Journal.

2. REORGANIZATION.

a. Reclassification and recataloging of 2,237 volumes, mostly recent books, has made them much easier to find and put away.

b. Open shelves have been installed in the Reading Room and will make many more recent books accessible to readers.

c. Glass-doored cases in Reading Room are now used to protect and display some of our valuable old books, now housed in the stacks.

d. The Periodical Room and the Librarian's Office were air-conditioned last summer, to the benefit of both patrons and staff.

e. Periodical subscriptions have been placed in the hands of an agent, in accordance with usual library practice. This saves money, time, and bookkeeping.

f. Visible record equipment has been purchased to consolidate the *five* former periodical record files into one, in the interest of efficiency.

g. Other new equipment has been purchased, including filing cabinets, book ends, an additional book truck, a postal scale, a bulletin board, etc., and has speeded up the work.

h. Space is being made in the basement, where heretofore only duplicates have been kept, for expansion of our original periodical collection, which is overflowing stacks 1 and 2. Removal of extra copies of Faculty publications to storage outside the building has released much-needed space for this purpose.

3. PLANS FOR 1954 include:

- a. More aggressive policy for purchase of new books.
- b. Better care of valuable old books and leather bindings.

The fine spirit of cooperation of all members of the library staff—Mrs. Henry Berge, Miss Myrtle Hollins, and Mrs. Ella Chatt—has been noteworthy.

THIS IS YOUR LIBRARY. YOUR SUGGESTIONS WILL BE WELCOMED.

Helen Wheeler, A.B., B.S.,
LIBRARIAN.

LIBRARY REPORT

January to December, 1953

CIRCULATION AND ATTENDANCE

Circulated books	3,623
Books used in Library	3,858
<hr/>	
Total	7,481
Total volumes in 1952	76,298
Books added, 1953	676
Journals added, 1953	446
<hr/>	
Total volumes in Library	77,420
Attendance	3,118

MEDICAL LIBRARY ASSOCIATION

Issues sent on exchange	2,275
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BINDING

Journals bound	583
Total cost	\$1,843.65
Average cost per journal	\$ 3.16

COUNTY MEMBERS

Requests filled	239
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GIFTS

Unbound journals	7,608
Bound journals	348
Books	1,248
Reports and pamphlets	105
Reprints	1,794
Pictures	2
Diploma	1
Museum pieces	1 case
<hr/>	
Total	11,107

RECLASSIFICATION AND CATALOGING

Volumes processed	2,237
Volumes withdrawn	12

INTER-LIBRARY LOANS

Loaned

Army Chemical Center	1
Baltimore City Health Dept.	5
Bon Secours Hosp.	1
Ft. Howard Hosp. Lib.	21
Johns Hopkins Univ.	6
Lehigh Univ.	1
Loyola College	2
Medical College of S. C.	1
Mercy Hosp.	2
Notre Dame College	3
Pratt Library	1
St. Joseph's Hosp.	40
Seton Institute	2
Sheppard Pratt Hosp.	13
Sinai Hosp.	31
Social Security Lib.	11
U. S. Army Lib. (Ft. Meade)	2
U. S. Dept. Agriculture	1
U. S. Pub. Health Hosp.	797
U. S. Vet. Admin. Hosp.	1
Univ. Maryland	4
Welch Med. Lib.	74
Wilmer Institute	8
<hr/>	
Total	1,028

Borrowed

Armed Forces Med. Lib.	6
Sheppard Pratt Hosp.	1
U. S. Pub. H. Hosp.	1
University of Md.	36
Univ. Minn. Farm Lib.	1
Welch Med. Lib.	32
Western Reserve Univ.	1
Wilmer Institute	2
<hr/>	
Total	80

PETTY CASH REPORT

Balance on hand Dec. 31, 1952	\$5.00
Received from office and refunds on express and postage, etc.	156.50
<hr/>	
Total	\$161.50
Expenses	136.68
<hr/>	
Balance on hand, December 31, 1953	\$ 24.82

Health Departments

STATE OF MARYLAND DEPARTMENT OF HEALTH MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, April 30-May 27, 1954

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARA- LYTIC	POLIOMYELITIS, NON- PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County.....	33	—	8	4	359	—	95	1	—	—	35	—	—	7	16	1	7	e-2	2
Anne Arundel.....	10	—	—	—	113	—	9	—	—	1	2	—	—	—	13	—	1	e-3	—
Howard.....	—	—	—	—	13	—	5	—	—	—	—	—	—	2	1	1	—	—	—
Harford.....	2	—	4	12	55	—	6	—	—	—	2	—	—	—	3	—	—	—	1
Carroll.....	2	—	1	—	19	—	—	—	—	—	21	—	—	—	2	—	—	—	—
Frederick.....	16	—	—	19	16	—	2	—	—	—	—	—	—	—	2	—	1	—	2
Washington.....	3	—	—	4	1	—	16	—	—	—	—	—	—	5	3	—	2	—	1
Allegany.....	—	—	—	3	4	—	5	—	—	—	9	—	—	2	1	—	1	—	3
Garrett.....	—	—	—	—	2	—	1	—	—	—	2	1	—	1	—	—	—	—	—
Montgomery.....	32	—	13	12	288	—	48	—	—	—	8	—	1	—	9	—	2	e-4	3
Prince George's.....	20	—	5	2	213	1	28	—	—	—	8	—	—	4	6	—	1	e-1	—
Calvert.....	2	—	—	3	1	—	1	—	—	1	—	—	—	—	1	—	—	—	—
Charles.....	4	—	—	—	—	—	1	—	—	—	2	—	—	—	—	2	—	—	—
Saint Mary's.....	3	—	—	—	41	—	2	—	—	—	2	—	—	—	—	—	1	—	1
Cecil.....	2	—	1	6	9	—	1	—	—	—	—	—	—	—	2	—	3	—	1
Kent.....	16	—	—	3	14	—	7	—	—	—	—	—	—	—	—	—	—	—	—
Queen Anne's.....	—	—	1	1	4	—	—	—	—	—	—	—	1	—	2	—	—	—	—
Caroline.....	—	—	—	—	7	—	—	—	—	—	—	—	—	2	1	—	5	—	—
Talbot.....	—	—	—	—	1	—	—	—	—	—	—	—	—	4	1	—	—	—	1
Dorchester.....	2	—	3	—	30	—	1	—	—	1	—	—	—	—	5	2	10	—	2
Wicomico.....	15	—	—	—	1	—	14	—	—	—	4	—	—	—	2	—	15	—	—
Worcester.....	4	—	1	—	67	—	—	—	—	—	1	1	—	7	1	—	—	—	—
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	5	—	—
Total Counties.....	166	0	37	69	1258	1	242	1	0	3	96	2	2	34	71	6	54		17
Baltimore City.....	138	0	11	5	616	2	138	0	0	2	78	0	0	34	96	4	572		14
State																			
Apr. 30—May 27, '54..	304	0	48	74	1874	3	380	1	0	5	174	2	2	68	167	10	626		31
Same period 1953.....	314	1	340	31	420	0	467	3	0	2	391	0	3	8	190	9	620		27
5-year median.....	465	1	218	—	610	4	252	3		3	110	2	3	31	238	37	521		39
Cumulative totals																			
State																			
Year 1954 to date.....	2656	6	213	468	9978	23	2148	4	0	5	1116	6	3	358	884	74	2937		282
Same period 1953.....	2480	8	1289	181	947	45	1357	4	0	2	1965	8	5	80	988	64	3137		431
5-year median.....	2593	18	775	—	3615	32	1098	11		4	749	9	15	194	1143	212	2709		331

e = encephalitis due to measles and mumps.

1 case of psittacosis was received from Montgomery County.

BALTIMORE CITY HEALTH DEPARTMENT

THE BALTIMORE CITY HOME INSPECTION PROGRAM

LET'S PREVENT THAT HOME ACCIDENT



Sponsored by THE BALTIMORE CITY HEALTH DEPARTMENT and THE BALTIMORE SAFETY COUNCIL

In Cooperation with the Schools of Baltimore City

DEAR PARENTS:

Accidents in the homes of Baltimore during the last five years resulted in more deaths than motor vehicle accidents, and many thousands more suffered serious disability as a result of carelessness. Accidents may strike at any time, in any place, even in YOUR home -- unless the causes are recognized and steps taken to eliminate them.

Can you or any one in your family afford to lose an arm, leg or sight, or even life itself? A few minutes of your time NOW, may spare needless suffering and expense. All we are asking is that you go through your home and look for the hazards indicated below. Get rid of any you find and resolve to change any accident-causing habits the family may have.

When the inspection is over and all the answers have been placed in the boxes under "YES or NO", detach the Answer Column and return it to the school, UNSIGNED. In this way you will help us to learn which hazards are most common in the homes of the community.

Thank you for joining your neighbors and schools in trying to make ours a safer city in which to live.

Sincerely yours,

Commissioner of Health

May, 1954

HOME SAFETY HAZARDS

ANSWER COLUMN

IN THE KITCHEN:

1. Do you keep lye, bleaches, cleaning fluids, rat and bug killers and matches out of reach of small children?
2. Do you keep all electrical equipment in good repair, discarding worn cords, broken plugs or switches?
3. Do you keep containers of hot food and liquids in the center of the table, and pot handles on the stove turned in out of children's reach?
4. Do you wash sharp knives separately and keep them and other sharp or pointed instruments out of children's reach?
5. Do you immediately clean up any spilled food, grease or liquid to prevent falls?
6. Are curtains, shelf coverings and drying laundry kept away from the stove so they cannot catch fire?

Check

YES NO

1 () ()
 2 () ()
 3 () ()
 4 () ()
 5 () ()
 6 () ()

IN YOUR BATHROOM:

7. Are all medicines kept out of the children's reach, labelled clearly, and destroyed when no longer in use?
8. Do you avoid touching electric switches, sockets and appliances while any part of your body or clothing is moist?
9. Do you stay in the bathroom with small children to prevent their being drowned or scalded?
10. Is there a non-slip mat or heavy towel for the bottom of the bathtub to prevent falls?

7 () ()
 8 () ()
 9 () ()
 10 () ()

HOW ABOUT THE BEDROOM?

11. Is there a light of some kind near the bed or the door so you need not walk or stumble in the dark?
12. Do you enforce the rule "NO SMOKING IN BED"?
13. Are all windows securely screened and fastened, and beds placed so that children cannot roll, bounce or climb out?
14. Do you keep pins, needles, scissors, and buttons in a sewing box high out of reach of small children?
15. Have you made sure paint on baby's crib and other furniture, window sills and other woodwork does not contain lead?

11 () ()
 12 () ()
 13 () ()
 14 () ()
 15 () ()

GENERAL LIVING AREAS:

16. Do you always use a strong, steady step-stool or ladder when trying to reach high places?
17. Are stairs and rails in good repair, adequately lighted, and kept free of all articles to avoid falls?
18. Do all small rugs and mats have non-slip backing or pads under them?
19. Are toys put away after play so that members of the family will not trip or fall over them?
20. Do you protect small children by the use of stairgates and a play pen?

16 () ()
 17 () ()
 18 () ()
 19 () ()
 20 () ()

IN THE BASEMENT AND YARD:

21. Is the heating unit or furnace in good repair, and the flues and chimneys tight and clean?
22. Are paints, varnishes, turpentine, etc., kept in tightly covered containers and out of the reach of children?
23. Do you get rid of oily rags, old papers and other trash promptly?
24. When you use cleaning fluids do you allow adequate ventilation and keep away from open flames?
25. Are all tools and garden equipment properly stored where people cannot fall over them or bump into them, and where children cannot get at them?

21 () ()
 22 () ()
 23 () ()
 24 () ()
 25 () ()

TEAR OFF HERE AND RETURN TO THE TEACHER

"Learn To Do Your Part In The Prevention Of Home Accidents"

(See explanation by Dr. Williams on next page)

(Baltimore City Health Department, continued)

Prevent That Accident!

Among the leading causes of death in the year 1953, accidents constituted one of the most preventable categories. Of 502 fatal accidents from all causes among residents of Baltimore City, 159 took place in the home, 168 were motor vehicle accidents, 39 were from occupational causes and 136 were in the miscellaneous "other public" category. Aware of the high prevalence of home accidents, the City Health Department last month joined with the Department of Education and the Baltimore Safety Council in a program designed to aid in producing a community appreciation of potential accident hazards in the home. This program was one in which school children were asked to take home a prepared letter and check-list for study with their parents. In a two-weeks period approximately 150,000 letters and check-lists were distributed.

Physicians can do much in disseminating in-

formation and interest in the prevention of accidents, most of which are due to carelessness, both in and out of the home. Accidents are now a leading cause of death. The physician is often in an advantageous position to discuss home safety practices, not only when called upon to treat an accidental injury, but also at other times as well. It is the hope of the Baltimore City Health Department that physicians will join the growing army of accident-preventers and help to teach the lessons the public needs to learn.

The circular letter to parents, shown on the opposite page, will be of interest and value in such efforts.

Huntington Williams, M.D.

Commissioner of Health

HARVARD SCHOOL OF PUBLIC HEALTH

Boston:—The Harvard School of Public Health will give postgraduate scholarships in amounts ranging up to \$5,000 to qualified candidates desiring to study at the School during the academic year 1954-56.

Eligible for Harvard School of Public Health Postgraduate Scholarships are:

1. Physicians, Dentists and Veterinarians interested in preventive medicine and seeking training in one or more Public Health specialties leading to either a Master of Public Health or Doctor of Public Health degree;
2. Industrial Physicians seeking training in Industrial Medicine leading to a Master of Industrial Health degree;
3. Public Health Nurses with a college degree and satisfactory field experience who wish additional Public Health training leading to a Master of Public Health degree;
4. Public Health Engineers seeking additional training and research experience in one or more Public Health specialties leading to either a Master of Science in Hygiene or Doctor of Science in Hygiene degree;
5. College Graduates with academic experience in the natural sciences who desire training and research experience in one of the sciences related to Public Health and leading to either a Master of Science in Hygiene or Doctor of Science in Hygiene degree.

Deadline for filing Scholarship applications is April 30, 1954. Scholarship winners will be announced June 1, 1954.

Application for further information about the Harvard School of Public Health Postgraduate Scholarships may be obtained by writing the Secretary, Harvard School of Public Health, 55 Shattuck Street, Boston 15, Massachusetts.

For more information, call: David S. Davies, Harvard School of Public Health, Telephone: Longwood 6-2380, Ext. 117 or 118.



Blue Cross - Blue Shield



NATIONAL ADVERTISING

R. H. DABNEY*

This past April, the 84 Blue Cross Plans and the 77 Blue Shield Plans, convinced that their common problems required a vigorous new approach on a broad national scale, launched jointly a nationwide program for public information and education. Although local programs, tailored to fit local needs, had demonstrated their effectiveness in the past, no such joint effort had ever been adopted.

By now, a national audience of some 71,000,000 people is well acquainted with the dignified, yet compelling, messages appearing regularly in *Life*, *Look* and the *Saturday Evening Post*. People who before knew little or nothing of the distinct advantages offered through membership in Blue Cross and Blue Shield are now becoming increasingly aware that they, too, should have the valuable protection which millions in their own communities have acquired.

Anyone who has been connected with the actual administration of the Blue Cross and Blue Shield Plans can readily appreciate the need for an organized and a systematic approach to the public market place. The problems have always been close at hand. It is conceivable, though, that other people, particularly people in the hospital field and in the medical profession, may not be as fully aware of the real reasons behind this new national program.

Principally, there are five significant problems which have confronted all Blue Cross and Blue Shield Plans. It is essential to know what these problems are—why they are problems—to understand the need, *now*, for concerted public information and education. And it is equally important to know that these problems have grown more acute, not less so, despite the tremendous growth in membership and the excellent service to subscribers.

(1) After enrolling 46 millions under Blue Cross and 29 millions under Blue Shield, it is evident that

* Executive Director, Maryland Hospital Service, Inc.; Maryland Medical Service, Inc.

new enrollments are becoming increasingly difficult and expensive to secure. Most of the larger organizations have already bought some type of coverage. The smaller urban and rural groups, where the need for protection is great, lag far behind.

(2) Despite tremendous growth and unequalled service, all Blue Cross and Blue Shield organizations are finding that cancellations—resulting when people change jobs, when subscribers pinch pennies, and when commercial carriers move vigorously into new areas—are biting dangerously into total memberships, even offsetting fresh enrollments in some localities.

(3) Commercial companies, experienced in selling other kinds of insurance, have entered the field of hospitalization and surgical coverage in force. Their broad advertising programs, almost unrebuted by the Blue Cross and the Blue Shield Plans, have stimulated their success.

(4) Too many Blue Cross and Blue Shield subscribers have become confused about the real purposes and advantages of their own memberships under constant pressure of conflicting commercial advertising. In fact, in many areas the true identities of Blue Cross and Blue Shield Plans have been obscured through the use of similar names and terms by commercial companies.

(5) Finally, numerous human and economic factors have worked to create a popular groundswell for some kind of hospital and medical-surgical protection. People want it; they feel that they are entitled to it. If their wants are not satisfied, such a strong social urge could easily ripen into a general demand for governmental intervention—at any cost.

These, briefly, are the problems which in themselves indicate clearly the objectives for this new joint approach to national information and education. Call it advertising if you will, but practically speaking, “advertising” only describes the media to be used, *not the purposes to be achieved*: (a) To inform and to educate the public, subscribers or not,

about benefits; (b) To report, in the institutional sense, upon the progress of Blue Cross and Blue Shield Plans; (c) To bring more and more subscribers into the programs; (d) To convince present subscribers that they should keep their memberships active; (e) To give doctors and hospitals credit for their roles in the programs; and (f) To counteract unfavorable, often misleading, comparisons already planted in the public mind.

To accomplish these objectives, experts have chosen magazine messages to carry the program in information and education. Other national media, they say, cannot match the initial effect of magazine advertisements which have multi-million readerships, provide uniform effect for all Plans, have long reader-life in homes and offices and, space-wise, are adequate to bring detailed messages to many people.

Local advertising in support of the national program will fit local needs where it did not exist

before. Here in Maryland, where the population is within easy reach of newspaper-radio-television coverage, messages and announcements entirely within the definition of our own not-for-profit, community-service Blue Cross and Blue Shield Plans will be used to back the national effort. Without such local support, the effects achieved nationally might be dissipated before they had much value locally.

There is general agreement that the real intent behind Blue Cross and Blue Shield would not be fulfilled if only a minority, consisting of the more alert or fortunate families, come under the programs. The fundamental concept now, as always, is to provide community-wide protection, not just for the best risks, but for as many people as possible within the areas served by the Plans. National advertising, a fast, sure, and inexpensive way to accomplish our common objectives, is just another approach to this one basic obligation.

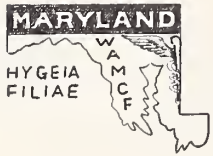
ALL OBLIGATED PHYSICIANS DUE FOR ACTIVE SERVICE BY JULY 1, 1955

The AMA Washington Letter, No. 60

During the next fiscal year, starting next July 1, the Defense Department expects that all hospital interns and residents obligated for military service will have to be called to active duty. However, according to Assistant Secretary Berry, the demand may not be as heavy during the first half of the period, due to a backlog of 1953 medical school graduates and a small number left over from Priority I. For the men facing almost inevitable calls, Dr. Berry urges hospitals to make short-term arrangements so they "will have a means of livelihood and also the opportunity to continue their education, as well as to contribute to the needs of the hospitals," while awaiting orders the last six months of this year and the first six months of next.

National Advisory Committee to Selective Service advises that after July 1, 1955, all physicians with military obligations should obtain commissions during their internships. This will remove them from the jurisdiction of their draft boards, and allow Defense Department to request delay in call for men the Department recommends for additional training.

This information is contained in a statement from Dr. Berry, in charge of medical and health matters for the Department of Defense. Dr. Berry also presented the results of a poll of medical school deans, who were requested to ask fourth year students the following questions: (1) If given free choice, which service would you prefer? (2) Do you prefer to serve your time immediately following internship? (3) Or following internship and one year of hospital training? (4) Or following full residency training? The results showed 27% of the students preferred the Army, 37% the Navy and 36% the Air Force. 39% preferred service immediately following internship, 15% preferred it after two years of hospital training and 46% preferred military duty after full residency training.



Woman's Auxiliary Medical and Chirurgical Faculty



MRS. JOHN G. BALL, *Auxiliary Editor*

MONTGOMERY COUNTY CELEBRATES DOCTOR'S DAY



Mrs. Emil G. Bauersfeld

Dr. Austin B. Rohrbaugh

Mrs. Norman Shoemaker

The above photograph shows Dr. Rohrbaugh, President of the Montgomery County Medical Society, being pinned with the official red carnation by Mrs. Norman Shoemaker, Doctor's Day Chairman. Mrs. Emil G. Bauersfeld, President of the Woman's Auxiliary to the Montgomery County Medical Society, takes part in the ceremony which was held on March 30, 1954.

DOCTOR'S DAY, MARCH 30, 1954

In those counties in Maryland in which Woman's Auxiliary to the County Medical Society is organized, doctors were seen wearing red carnations, the official flower, in honor of Doctor's Day. In many hospitals, arrangements of red carnations were placed in memory of deceased doctors.

In some of the counties, doctors were honored by special parties in addition to the carnation bou-tonnieres.

In Washington County, the student nurses at the Washington County General Hospital honored the doctors and their wives at a banquet, March 28th, which was a wonderful success.

In Baltimore County, on March 29th, a Dinner-Dance was held at the Lord Baltimore Hotel and was a most enjoyable affair.

In Prince George's County, on March 30th, a buffet-luncheon was held in Prince George's Hospital. Many radio stations in the State carried spot announcements or even special talks on Doctor's Day.

We are in hopes that people will stop and think a minute about the doctor they usually think of only when they are sick. We would have the citizens of Maryland pause this one day by Governor's Proclamation, to honor the men and women who work every day in the year for the benefit of humanity.

FUTURE NURSES CONVENTION

May 1, 1954

Early in April, invitations were sent to all Senior High Schools in the state of Maryland, inviting any junior or senior high school girls who were interested in nursing to attend our Future Nurses Convention. Girls from many counties attended. They were most enthusiastic and attentive to the day-long program. The program following was their guide for the day.

One of the high points of the day was the Parade of Student Nurses. The girls were eager to see just how they might look if they should attend one particular school. The becoming caps seemed to be the focal point of the uniform. Since they were all wearing Future Nurse paper caps, they had their first "feel" of being "capped." The following hospitals sent Student Nurses to the Convention: St. Joseph's Hospital; Bon Secours Hospital; St. Agnes Hospital; Sinai Hospital; Church Home and Hospital; Mercy Hospital; Lutheran Hospital; Franklin Square Hospital; Provident Hospital; Johns Hopkins Hospital; Woman's Hospital; Maryland General Hospital; University Hospital; Union Memorial Hospital.

The Future Nurses Club delegates were very interested in just what other clubs did and how big they were. This part of the program was for the girls themselves and they really took over.

As a fitting close to an inspiring day, the Maryland Nurse Recruitment Film, "The Girl with the Lamp," was shown.

Among our guests for the day were: Mrs. Harold Johnson, National Nurse Recruitment Chairman; Dr. Samuel McLanahan, Adviser to Woman's Auxiliary; Miss Elizabeth Hagarty, President of the Student Nurses Council of Maryland; Representatives of the Maryland League for Nursing and Maryland State Nurses Association.

Mrs. Harold Johnson, National Nurse Recruitment Chairman was very enthusiastic about our Convention. She felt it was very worthwhile and was happy that she had the opportunity to see it firsthand.

The following pamphlets were given to the girls to help them in deciding which nursing course best suited their abilities: "Team Mates," a folder on practical and professional nursing; "Nursing has a Future for You;" "There is an Exciting Future for you in Public Health Nursing."

As an outgrowth of the Future Nurse Clubs delegates' meeting, at the Future Nurses Convention May 1st, the girls appointed Miss Gay Kaiser, Carroll County, as temporary chairman, to form a State Future Nurses Club organization. Miss Joyce Wheeler, Baltimore County, chairman of constitution and by-laws. Sample constitutions were furnished by Mrs. Harold Johnson, National Nurse Recruitment Chairman. An organization meeting was held at the Medical and Chirurgical Faculty Building on May 15th, under the auspices of the State Auxiliary.

Future Nurses Convention Program

Second Convention

FUTURE NURSES OF MARYLAND

Saturday, May 1, 1954

Towson High School

Cedar Avenue, Towson, Maryland

Sponsored by: Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland, Mrs. Albert E. Goldstein, President, presiding

9:45-10:00 Registration; Girls get Future Nurse caps to wear during convention

10:00-10:05 Lighting of Nightingale Lamps by nurses in uniform

Invocation, Reverend Mr. Bennett Sims

10:05-10:30 "The History of Nursing", A. Stuart Chalfant, M.D.

10:30-10:50 Panel on Courses (5 minutes each)

1. Diploma, Miss Eileen McCoy, R.N.

2. Collegiate, Sister Josephine Cavanaugh, R.N.

3. Practical, Mr. Herbert Johnson, President, Practical Nurses Association
4. Examination for State Board of Nursing License, Mrs. Bessie Parr, R.N.

10:50-11:00 Panel Questions

11:00-11:40 Panel on After Graduation (5 minutes each)

1. Private Duty, Mrs. Hortense Tegler, R.N.
2. General Duty, Mrs. Norma Miller, R.N.
3. Public Health, Mrs. Eileen Troop, R.N.
4. Institutional, Miss Louise Hohener, R.N.
5. Educational Administrators, Consultants and Teachers, Sister Mary Florence, R.N.
6. Industrial, Miss Margaret Kramer, R.N.
7. Army Service, Captain Helen Ely, A.N.C.
8. Special Groups, Miss Dorothy P. Metzler, R.N.

11:40-12:15 Panel Questions

12:15- 1:00 Lunch (Girls bring own lunch; drink furnished)

1:00- 1:45 Parade of Student Nurses, Baltimore Hospitals

1:45- 2:00 Baltimore Student Nurse of the Year will speak. Student Nurse to be chosen at Medical and Chirurgical Faculty Ball from candidates from all nursing schools in Baltimore

2:00- 2:30 Future Nurses Clubs. Each club has a delegate

2:30- 3:00 Film: "Girl with the Lamp" Courtesy Woman's Auxiliary to the Baltimore City Medical Society and Maryland Society for Medical Research, Inc.

Committee:

Nurse Recruitment Chairman: Mrs. James Kerr

Arrangements: Mrs. D. D. Caples, Mrs. Thomas Webster, Mrs. John G. Ball

Publicity: Mrs. Charles H. Williams

NEWS NOTE

Woman's Auxiliary Produces Film For Nurse Recruitment

The Woman's Auxiliary to the Baltimore City Medical Society, with the aid of the Maryland Society for Medical Research, Inc., and the teaching hospitals of Maryland, has produced a film for Nurse Recruitment entitled, "The Girl with the Lamp." It is a 16 mm. color film with sound, that runs for twenty minutes. This film is available without charge, as a public service of the Auxiliary, for showing in Junior and Senior High Schools, before parent and teachers' groups, civic, women's or church groups, and to religious and community young people's associations.

The film shows not only what a student nurse will actually study, but how she will live and some of the lighter moments of student life. It was made

with the advice of the Maryland State Nurses Association.

Your organization can obtain the picture for showing from the Woman's Auxiliary to the Baltimore City Medical Society, Committee on Motion Pictures, 1211 Cathedral Street, Baltimore 1, Maryland.

NATIONAL CONVENTION, SAN FRANCISCO, CALIFORNIA

The thirty-first annual convention of the Woman's Auxiliary to the American Medical Association will be held in San Francisco, California, June 21 to 25, 1954. Headquarters will be at the Hotel Fairmont.

The following Auxiliary members from Maryland are planning to be there: Mrs. George H. Yeager, National Constitutional Secretary; Mrs. A. E. Goldstein, President; Mrs. James Kerr, Nurse Recruitment Chairman; Mrs. Gerald LeVan, President-Elect; Mrs. Bender B. Kneisley; Mrs. J. W. Bird; Mrs. H. T. Morse.

SUMMER READING

Some of us may have more time to read in the summer than during the busy winter months, so here is a list of medically slanted (for the greater part) books.

Fiction

"The Doctors"—André Soubiran (Medical life in Paris)

"Not as a Stranger"—Morton Thompson (The making of a doctor)

"God and My Country"—MacKinley Kantor (For anyone who has a boy or Boy Scout)

Non-fiction

"Autumn of Liberty"—Paul Harvey (Posing a great question)

"An Alcoholic to His Sons"—as told to Henry Beetle Hough

"The Great Medical Bibliographers"—John F. Fulton (interesting men themselves)

"The Motion of the Heart"—Blake Cabot, M.D. (For the layman)

"The Allergic Child"—Harry Swartz, M.D. (Primarily for parents with this problem)

COMING MEETINGS

TAKE NOTE!

SEMIANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY

⇨ October 14, 1954 ⇩

Hagerstown, Washington County, Maryland

Watch for more details regarding this program, but mark the date on your calendar, so that you will be "among those present."

* * * * *

SIXTH CONGRESS ON OBSTETRICS AND GYNECOLOGY SET FOR DECEMBER 13-17

The sixth American Congress on Obstetrics and Gynecology will be held at the Palmer House, Chicago, December 13-17, 1954.

The five-day meeting is sponsored by the American Committee on Maternal Welfare, Inc., and the American Academy of Obstetrics and Gynecology. It will bring together the four major groups concerned in the provision of better care for mothers and babies—medicine, nursing, public health and hospital administration.

The program will include twenty-seven formal papers, twenty-two symposia and panels, luncheon discussion groups, and several hundred round-table discussions, covering every phase of maternal and newborn care. Scientific and technical exhibits are also being planned.

Information about the meeting may be obtained by writing to the Sixth American Congress on Obstetrics and Gynecology, 116 South Michigan Avenue, Chicago 3, Illinois.

YOUR JOURNAL!

Publication of the MARYLAND STATE MEDICAL JOURNAL represents less cost to the membership than when a BULLETIN and NEWS LETTER were published. The cost of the Faculty Transactions, which are now current, is absorbed by the JOURNAL. Formerly they were published on an accumulation basis of five to ten years.

A.M.A. NEWS RELEASE—WASHINGTON OFFICE

May 7—1954

Washington, D. C.—At the request of the Defense Department, Congress is considering a bill to expand and make more uniform the medical care program for civilian dependents of military personnel. It could have significant impact on the practice of medicine and on medical economics.

The legislation developed out of the Defense Department's Moulton Commission report of a year ago. In the intervening months the department's legislative planners called in representatives of the American Medical Association and other professional groups for advice. But the bill finally presented to Congress is evidence that not all differences of opinion were compromised. While in many respects the measure is in line with the policy of AMA on dependent care, at least one basic conflict remains:

The department's bill states that dependents should receive private medical care only when military facilities are unavailable or inadequate. The AMA's policy, adopted after long study of the problem, is that dependents should be cared for in military hospitals and by uniformed physicians only when civilian care is inadequate or unavailable.

There is almost complete agreement that the present patchwork dependent medical care program should be changed to make benefits uniform geographically and within the services, and to spell out the benefits in law. The issue is whether the military medical services should care for all qualified civilian dependents, or dependents should, like the rest of the population, get their medical care from civilian physicians and hospitals.

Under the bill, medical care furnished by or underwritten by the federal government would be limited to "diagnosis, acute medical and surgical conditions, contagious diseases, immunization, and maternity and infant care." Dental care would be allowed only in emergencies or as an adjunct to medical care. These restrictions would be waived overseas and at remote stations in the United States.

The definition of "dependents" would not extend beyond parents and parents-in-law, and these relatives would have to receive at least half their support from the military member to qualify.

The Secretary of Defense would decide what charges, if any, to levy against dependents treated at military facilities. When treated privately, the dependents would pay the first \$10 cost of any illness, plus not more than 10% of the total cost. The secretary could make use of voluntary health insurance for dependents if this system were found to be more economical.

The Senate Armed Services Committee was slow to take up the dependent care bill because of a heavy schedule of other hearings. Nor did it make fast progress in the House. There the introduction of the bill was delayed when Chairman Dewey Short (R., Mo.) called on Defense Department to furnish him with detailed information on what the new medical care program would cost.

By mid-May, when Congress had about concluded hearings on all major administration health bills, a new factor was introduced. Chairman Wolverton of the House Interstate and Foreign Commerce Committee called hearings on his own bill for federal guarantee of private loans to health facilities. This was not part of the original Eisenhower health program, but there were some indications that the administration might get behind it.

As originally drawn, the bill would virtually exclude all clinics and hospitals except those operated in conjunction with prepaid insurance plans. During the hearings, Mr. Wolverton indicated he would be willing to drop this restriction. If this were done, the law then would offer benefits to all—fee-for-service physicians and groups as well as "closed panels."

During this period, some sentiment developed to combine the loan guarantee bill with the reinsurance bill, which wasn't making much progress on its own. The result was a period of

confusion and uncertainty, with no clear indication of what either the committee or the administration really wanted.

A few other medically-important bills were advancing on schedule. The House Ways and Means Committee gave every indication of reporting out a bill to require all employers (physicians included) to participate in the federal-state unemployment insurance program. As usual moving faster than the Senate, the House had passed a bill to give state health officers more control over federal grants for public health work. The House also was nearing a vote on extension of the social security program, with no suggestion that physicians and other self-employed groups who don't want coverage would be exempted. The House-approved Hill-Burton expansion bill was waiting action in the Senate.

MANION COMMISSION STARTS SURVEY OF GRANTS IN FIVE STATES

A. M. A. Washington Letter, No. 58

On contract from the Commission on Intergovernmental Relations, private research organizations have started a study of five states "widely representative of the national picture" to determine the impact of federal aid programs on state and local governments. The states are Kansas, Wyoming, Michigan, Mississippi, and Washington. Twenty-two federal grant programs representing 87% of the nearly \$3 billion spent annually for all federal aid, will be investigated. Included will be hospital construction, general public health, venereal disease, tuberculosis, mental health, cancer, heart disease, and housing and slum clearance. The commission explains: "The surveys are expected to enable the commission to recommend what functions, if any, should be reallocated as between the federal, state, and local governments, and what modifications of existing procedures in the federal aid programs are necessary to eliminate overlapping, unnecessary controls and excessive costs."

The law creating the commission specified that its report was to be made to the President by March 1, but this is now impossible. At that time some findings will be available for release, a spokesman for the commission said, but it has not been decided whether this information will be made public piecemeal, or held until a more complete report can be compiled. The five-state study is to be completed in 90 days.

A. M. A. Washington Letter, No. 58

A Veterans Administration report estimates that since 1944 some 180,000 veterans have studied medicine or related courses under the GI bill of rights; about 300,000 veterans are still in training under the broad program which expires in 1956. . . . An Office of Defense Mobilization manpower study states that in event of full mobilization greatest personnel shortages would occur in health, scientific and technical fields; raising the nation's physical and mental level is perhaps the greatest potential addition to military manpower resources, the report adds. . . Atomic Energy Commission has announced in its semiannual report to Congress the completion at Los Alamos, N. Mex., of the only health laboratory exclusively for research in hazard aspects of atomic weapon development. . . Brig. Gen. Alvin L. Gorby, senior medical advisor to the Assistant Secretary of Defense (health and medical), has been appointed deputy commander of Walter Reed Army Medical Center . . . Effective July 1, Army Medical Service residency program in anesthesiology will be increased from two to three years . . . V. A. reports an urgent need for social workers, dietitians, biochemists, X-ray and medical technicians, and therapists for V. A. hospitals.

VACANCY

It is anticipated that there will be several vacancies on the residency staff in Internal Medicine at the VA Hospital, Fort Howard, Maryland, commencing July 1, 1954. Interested physicians are requested to communicate with Dr. Francis G. Dickey, Chief of Medicine, at the Veterans Hospital.

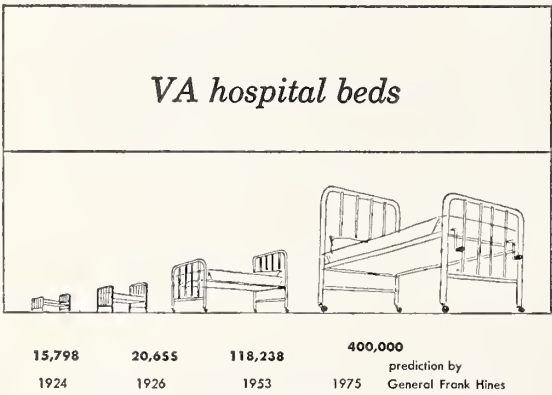
“MUST WE FOLLOW THE VA ROUTE TO SOCIALIZED MEDICINE?”

Have you read this article which appeared in the March issue of the Reader's Digest? It is an independent view of the facts upon which the House of Delegates of the American Medical Association has based its adopted policy on the VA medical care program.

Dr. Ralph G. Hills, the Chairman of the Medical and Chirurgical Faculty's Committee on Veterans' Medical Care, urges every physician to read the article, and also advises that reprints be placed in your offices so that your patients may be informed regarding this subject.

Reprints may be obtained by writing to Dr. Louis M. Orr, Council on Medical Service, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

In Viewing the VA Medical Program . . .



Former VA Administrator Frank Hines estimated that by 1975 under existing VA medical legislation, approximately 400,000 hospital beds will be needed. Yet medical authorities are convinced the VA cannot attract sufficient medical personnel to staff more than 120,000 beds. The VA now maintains three times the number of beds needed for treatment of service-connected cases.

In Viewing the VA Medical Program . . .

average length of stay in VA hospital

	Average (days)	World War II (days)	World War I & Other (days)
TB	205.8	203.6	210.2
NP	178.3	89.2	430.6
GMS	30.8	23.5	42.5

The average length of stay in VA hospitals for World War I veterans is considerably greater than for World War II veterans, which now comprise 76% of the total veteran population. The greatest pressure is yet to be exerted on VA hospitals as World War II veterans grow older and require increased medical care for disabilities unrelated to military service.

Maryland STATE MEDICAL JOURNAL

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VOLUME 3

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NUMBER 7

Scientific Papers

MEDICAL-PSYCHIATRIC COLLABORATION

WENDELL MUNCIE, M.D.

In discussing medical-psychiatric collaboration it is customary to begin by mentioning the catalog of illnesses in which such collaboration may be fruitful. Not so many years ago this aspect of the problem was important, for then we psychiatrists were in the pioneer stage of pressing our new contributions onto the general medical consciousness. That phase is largely past and today there is a wide acceptance of the fact that personality disturbance—essentially emotional and attitudinal—plays a great role, sometimes the dominant one, in many sorts of illnesses. So it may be said that in the last twenty-five years, the outstanding development in psychiatry has been its entry into that world outside the specialized psychiatric hospital.

The admitted potential value of psychiatric effort is at the mercy of its participants. It is eternally being compromised by them: the psychiatrist, his medical colleague, the patient and his family. I shall comment on the following topics: 1) Problems in the practice of psychiatric referral; 2) problems in the practice of psychiatric reporting; 3) complaints against medical

colleagues by psychiatrists; 4) complaints against the psychiatrist by our medical colleague; 5) breakdowns in collaboration. Lastly, I shall comment on community treatment facilities. Before I launch into my theme, laden with criticism of ourselves (psychiatrists) and of you (medical colleagues), I want to testify from my years of experience that there is no greater gratification to be obtained than from successful collaboration with medical colleagues of every speciality. I never cease to wonder at the variety of problems with which the general practitioner deals, and at the great body of intuitive personality evaluation he constantly must employ. That this acumen is largely unorganized, and that he has not adequate time to devote to its development furnish the reasons for the existence of such people as I.

The practicing physician's examination is the patient's first line of defense in illness of all sorts. Resting on the time-honored, if biased, custom of giving physical illness precedence in our thinking over mental or emotional illness, this screening process has great justification, but it also is the cause of much error in patient man-

agement. It is a rare patient who does not show something out of the way on examination. Immediately then it becomes a matter of judgment concerning the significance of these findings for the final complaint. The screening physician commonly passes on this phase of the matter without reference to the specialist's opinion. As a consequence, not a few cases come to a doubtful judgment, or at least a tardy one.

Today in Baltimore there are approximately seventy-five practicing psychiatrists. All are quite busy. A good share of their patients are referred by medical colleagues. Yet, I believe it safe to say, that, of the 1500 physicians in Baltimore, only a handful use psychiatrists regularly for diagnostic and treatment referral. At some time any one of the 1500 may call us asking for help with a patient who suddenly has developed an acute hallucinatory state with or without toxic accompaniment, or who has threatened suicide, or actually made a suicidal attempt, or is so excited as to make living in society impossible. In short, the emergencies are commonly recognized as such, and we are used promptly to relieve the physician of further responsibility. This usually means arranging for hospitalization. But even in emergencies I have seen an occasional mishandling of the referral: for instance, in arranging for office electroshock therapy of a case of deep depression without a good preliminary psychiatric evaluation of the basic condition, or without consideration of whether this is the optimal time for the administration of the electroshock, and whether it should be given in hospital or outside. I regret to relate that some so-called psychiatrists lend themselves to such a procedure.

Far fewer physicians use us for help in the non-emergency conditions constituting about one-third of all cases in general medical practice. These are the psychosomatic diseases and the psychoneuroses. The great error in referral here is in its tardiness. Often, by the time such cases come to us, they have had months or years of medical treatment with palliatives for symptoms,—especially vitamins, sedatives, anti-

spasmodics, and superficial psychotherapy in the nature of reassurance, exhortation, rest cures, vacation trips, change of job, etc. Without denying that such measures may occasionally have an incidental value, it must be asserted that such patients are rarely appreciably helped by them. This is inevitably the case since the sources of the disorders lie in the faulty attitudes developed over a lifetime, and are to be modified only by long-continued therapy of an analytic-synthetic sort. Even so, intensive psychotherapy may or may not be successful, but in any case the task is made more severe by the relative chronicity of the illness before it is undertaken. The error here is in underestimating the gravity of such conditions, and in maintaining a hopeful expectant attitude which is unjustified by the facts,—as if inner turmoil could be exorcised by authoritarian and sympathetic approaches.

At the same time, I must recognize that much valuable time which erroneously appears wasted to us has in fact been used for that most important item: the development in the patient of a willingness to accept psychiatric referral. Many times my colleagues have told me of the struggle they have had over this point. And even when I have not been told, I have noted the excellent preparation of the patient for the event. My plea is for the recognition of the need and the application of the best judgment as to when to insist if necessary on referral.

Too often referral of such patients is not for psychiatric treatment, but for a statement of specific methods which the referring physician may employ. Inevitably our report recommending the need for long-term psychotherapy meets with disappointment from our colleague, to say nothing of the patient, who may have been over-sold on the value of a single psychiatric conversation.

Not a few psychoneurotics come to psychiatrists only after forcibly breaking loose from a physician who turns a deaf ear to their requests for psychiatric help by minimizing the difficulty. This is especially the case in patients with

chronic anxiety who have cooperated with, but not prospered under, a regime of sedatives, reassurance as to the cardiac status and encouragement. Yet these are among the most favorable cases for psychiatric treatment. The failure in referral must rest on a misreading of the gravity of such situations and an overly optimistic expectation from symptomatic treatment. It can not be stressed sufficiently that symptomatic treatment in such cases should never be extended beyond a few weeks without seeking psychiatric evaluation and treatment. Psychoneuroses can not be expected to resolve themselves with time. They tend to become more fixed and to extend their sway with the production of more handicapping symptoms in the absence of vigorous and searching psychotherapy.

Fortunately for everyone concerned, the time is largely past when patients are sent to us expecting us to be anything except psychiatrists. Not in a long time have I been referred to as a "neurologist," or that sugar-coated euphemistic "nerve specialist." The candor and frankness in referral is all to the good. I believe patients to be far less sensitive about being referred to psychiatrists than some physicians have thought them to be. The same rule applies here as in all other referrals: namely, the physician must know why he wants the psychiatrist's help, what he hopes to gain from it, and why he picks the psychiatrist of his choice. Also, he must be willing to state these facts to the patient. To handle these items well, presupposes a considerable fund on the physician's part of diagnostic acumen, psychiatric intuition, and acquaintanceship with the psychiatric talent in his community.

Many patients come in such a way that I have no advance idea as to why they are sent or what they have been told. In practice actually this is not as bad as it sounds, for I find a certain merit in beginning my conversations with the patient on a completely neutral note, with no hint of prejudgment of his case. In most instances such a naïve approach will unearth the

essential facts of the illness, and often new facts not vouchsafed to the original physician. Also the patient's insight into his difficulties, and his urge for treatment as well as the degree of his treatability will come to preliminary judgment. Discussion then with the referring physician will round out the inquiry. Most of my busy diagnostic colleagues pursue this method.

The most natural method and the one most useful to the patient is that followed by a few old and tried colleagues, who call me on the phone and say: "I have sitting alongside me Mrs. K., who has such and such complaints for which I find no good explanation in my physical examinations. She is nervous, worried, or anxious, and has certain problems which I want her to talk over with you. She is willing to come. Any suggestions you make will be welcome." This method provides a basis of open collaboration, transferring to us the patient's confidence in her own physician, and assures that the consultation is free of resentment on her part for being sent, or of any suspicion of things being done to her behind her back. It allows the maximum leeway for discussion directly with the patient of the possibilities and alternatives in psychiatric treatment, a matter coming best from us since we are best qualified to make the recommendation.

Needless to say, the material of the whole diagnostic survey may be so complex that the psychiatrist's contribution and discussion must be hedged in with the proviso that it is subject to the weight of other factors known only to the physician charged with the survey, who must then have the final say in the recommendations.

A report should give the full complaint (often not the same as that given to the medical colleague), its historical development, the background including the health, social, economic, sexual, and marital states, the present mental condition, together with treatment opportunities, including the patient's openness to treatment, and if possible the specific recommendations for treatment. In the years I have been doing consulting work, I have noted a marked

improvement in the quality of the referring data offered by my colleagues, and, I believe, an equal improvement in the quality of the reporting.

Let us inquire more closely into the complaints we have with each other in regard to referral and reporting. I enumerate these unpleasant items as they have come to my attention for the single purpose of stimulating discussion to the end that better service may be given our patients. First, we find that the referring physician has an undue expectation from psychiatric consultation and treatment. I have noted repeatedly that we are expected to produce a "quickie-cure" through prescribing a way of life with a detailed program for the day, week, month, and giving direct counsel (actually a type of intervention) in the most vital and intimate matters, e.g., about business changes, marriage problems, separation and divorce, and especially about sex practices. Often the patient himself has been led to an undue expectation from ex-cathedra management of his problems. This attitude to treatment derives from the authoritarian situation which prevails so largely still in the field of general medicine, and which erroneously is extended to psychiatry. Modern psychiatry operates by collaboration relying on the patient to make his own decisions when he is fully aware of all the facts of his problems. Our job is to assist him in understanding these facts. Direct intervention is rarely our privilege, and in any case may not be made without the thorough establishment of a favorable soil for it in a collaborative study of the patient's life and personality. When this is done, direct counsel is rarely necessary, for the patient will come to his own decisions, as he should, since he alone has to live by the consequences of his decisions.

Our report in such a case fails to strike a responsive chord in physician and patient, and some disappointment or resentment is generated by the statement that the patient needs extensive psychiatric treatment. The ideal recom-

mendation may not correspond to the practicalities of the situation, especially the financial facts, and the available treatment facilities; and when this is the case, there is the obligation to consider possible if less desirable treatment.

Another difficulty comes from the failure to reach agreement as to who is to be in charge of the patient's over-all treatment, or who is to treat what aspects of the problem. Two sorts of crises arise from this breakdown in liaison:

1) The collaborating physicians fail to keep each other informed of the patient's progress, a potentially hazardous matter in certain psychosomatic conditions.

2) The patient pits one physician against the other, and nullifies imperative needs in treatment. I still remember a defeat administered me in psychiatric treatment by a paranoid patient who appealed to her medical advisor, who had earlier referred her to me for treatment, to get rid of me over a trifling matter which should have been made the material for further analysis of her sick attitudes. Instead, he operated by the rule that the patient must be kept satisfied at all costs, and, with inadequate presentation of the case to me, acceded to her request.

Then there is that failure in clear statement of treatment procedure which leaves the patient free to undertake treatment with the psychiatrist, at the same time pursuing independent treatment with one or more other physicians, of whose very existence the psychiatrist may be quite unaware.

Psychiatrists are quite sensitive to the fact that a medical failure with a patient under psychiatric treatment is the object of condemnation at medical and lay hands to a degree which never pertains in the opposite situation: a psychiatric failure under medical care. As a consequence we tend to lean over backward seeking medical help, especially for that growing number of patients who are coming to us directly without medical referral. It would be a good thing if we all were to admit that very few physicians are qualified to give both first-rate

medical and psychiatric help, and act accordingly.

I have noted a tendency for referrals to come in batches from any one colleague, followed then by a long lapse, and again they come my way. I have assumed, with some corroboration from my fellows, that this means I am used until I fail on a case, when the referrals go to another until he fails, and finally my turn comes again, unless of course my original failure was especially painful in some respect. This merry-go-round may result finally in the physician "doing his own psychiatry," to quote an eminent colleague. I shall not challenge this self-assumed designation further, for by definition any interpersonal relation which has for its end the influencing of behavior is subsumed under the term "psychiatry!" But I must also note, with some regret, the opposite situation: the stopping of referrals from a valued colleague on the occasion of a signal psychiatric success after prolonged medical efforts have failed. To my surprise, I have seen the physician react with overt anger toward the patient for not continuing the former dependent relationship with him. There are probably cases in which the reverse roles have been played by psychiatrist and physician. Fortunately, most of us control our prestige needs rather well, and such instances are rather rare in my experience.

TO SUMMARIZE

We psychiatrists complain because:

- 1) Patients are sent too late for the best treatment effort;
- 2) Too much is expected too quickly of us in the treatment of chronic patients;
- 3) We too often are not given a free and unobstructed hand in treatment;
- 4) We are expected to give a blueprint for psychiatric treatment which the physician can follow without any knowledge on our part of his psychiatric capacities.

Now to mention some of the complaints which have come to my ears about us.

Our colleagues complain because:

- 1) Our reports are full of big words—and Greek at that—which if not actually unintelligible, fail to help;
- 2) We tell the patients nothing at all, or stir up resentment in them, which the colleagues must subsequently deal with;
- 3) We do not take into sufficient account the privileged position of the referring colleague as family physician, a role rather different from the specialist's;
- 4) When we take over treatment, that is the last they ever hear of the patient. There is no follow up report.
- 5) We are often said to be more peculiar than the patients sent to us for treatment;
- 6) We are never available when needed since our time is always taken up;
- 7) Our fees are high and psychiatric treatment is too expensive for many patients.

If our reports in fact are not enlightening, then we have failed. That we say little is inherent in our material and our method. Our purpose is to encourage the patient to talk and find his own solutions. Nevertheless, no consultation patient should be left with the feeling that he was roasted on a spit by the psychiatrist and got nothing in return.

I shall not attempt to defend the personalities except to say that a surprising number of us who are peculiar, at least know it, and try to do something about it through constant exploration of our own personality structures. It is true that our time is reasonably full, and this will continue to be the case until there are more psychiatrists and they are better distributed about the country. Extensive treatment *is* too expensive for many patients and this is a powerful force leading to experiment with shorter methods of treatment, and to certain abuses to be mentioned later. Also community facilities for low-cost treatment are at a minimum.

How does one pick a good psychiatrist for any job? The good psychiatrist has personal integrity, maturity of outlook and judgment, an awareness of social forces, and technical com-

petence especially in the field of psychotherapy. In late years the so-called shock therapies and psycho-surgical techniques have revolutionized certain aspects of treatment. Nevertheless, psychotherapy remains the backbone of psychiatric treatment, and the only method to be employed in the large number of office cases. All cases need psychotherapy, and the drastic methods should best be considered not as alternatives but as helpful aids to psychotherapy. Yet many practicing psychiatrists today have too little training in psychotherapy. In the large centers crowded with psychiatrists, one finds the most active exponents of psychotherapy. Conversely, in areas sparsely supplied with psychiatrists the shock methods tend to supplant intensive psychotherapy, due, I believe, to the heavy case load which makes it virtually impossible to devote the time necessary to intensive psychotherapy. The psychiatrist finds himself forced to spread himself too thinly ministering to so many aspects of the community life.

The choice of a psychiatrist is too often made through the simple fact that there is only one to be made, a consequence of the poor distribution of psychiatrists over the country, a condition notably better today than before World War II but still highly unsatisfactory. The young man going into practice tends to remain close to his training center for professional reasons, and because of his fear of working in isolation. He feels safety rests in numbers.

But assuming that there is a choice, how can you be sure your psychiatrist colleague fulfills the criteria above? The acid test comes only with time and rests on demonstrated character, and results with patients. I am of the opinion that the young psychiatrists today meeting the requirements of the American Board of Psychiatry and Neurology are measurably better trained than we were twenty-five years ago. Specifically, young men today have a great interest in psychotherapy, as shown by the many who pursue additional psychoanalytic training. How many continue to grow and go on

to achieve real distinction is another matter with which we need not detain ourselves.

It remains to point out that the psychiatrist's effectiveness in his community parallels closely the community facilities for treatment,—in hospital facilities and social service agencies. The older specialized psychiatric hospitals commonly have closed staffs. Some newer units are admitting visiting men to the staffs. This development is more prevalent in the Midwest and Southwest than in the East. The psychiatric unit within the community general hospital with adequately trained nursing and supervisory personnel and special treatment means is the best answer to the problem of hospital facilities. Many short-term illnesses can be handled easily there, and preliminary diagnostic workup may best be done in chronic cases later needing prolonged care in specialized psychiatric hospitals. A growing number of Blue Cross Plans pay for psychiatric illness and should be a big factor in the extension of the use of such facilities. The hospital part of a patient's treatment may be materially shortened when the pre- and post-hospital phases are also in the same psychiatrist's hands—a valid reason for the establishment of a visiting psychiatric staff. The visiting psychiatrist should be as familiar a figure in the general hospital as his medical and surgical colleagues.

When psychiatric enthusiasm is fully discounted, the number of illnesses in which the psychiatrist can be helpful is still large. The potential value of psychiatric-medical collaboration finally must rest on adequate skill, adequate facilities, and adequate mutual understanding of the best methods to achieve smooth and efficient working relationships. While no one can always win, the percentage of wins can be greater than it often is if we confront ourselves always with the question: What can I do to give the patient a better break than he is getting up to this point?

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OPHTHALMOLOGY IN GENERAL PRACTICE

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The purpose of this paper is to discuss the eye conditions most frequently encountered in general practice. It is impossible to cover the entire field of ophthalmology in any single paper but the major eye disorders that should be recognized by the general practitioner and receive attention have been included. This includes some of the specific eye diseases such as glaucoma and cataract, as well as those eye conditions that arise as part of some general systemic disease. The eye cannot properly be considered solely as a highly specialized organ of perception but as an important part of the entire body affected by constitutional conditions as well as by its own special group of diseases. The general health of the patient may well be a factor in the functioning of this organ and conversely a local eye disease which produces poor vision will have a profound effect on the patient physically, mentally and economically. In the final evaluation of the patient, the eye condition should be viewed in its proper perspective in the total picture.

HEADACHE

Headache is one of the most frequent complaints encountered in the practice of medicine and the role of eyestrain as a cause of headache may be difficult to assay from the patient's history. There is no typical headache associated with eyestrain. It occurs most frequently in the region of the eyes but may be referred to any part of the area of distribution of the first division of the 5th or upper cervical nerves. It may remain limited and unilateral or become generalized. It may be mild in nature and difficult to localize, it may be deep-seated and boring, full and throbbing or sharp, shooting and lancinating. Its onset is usually associated with use of the eyes. If the headache is present upon awakening in the morning, it is doubtful that

the eyes are at fault. It is extremely doubtful that true migraine ever has its origin in a refractive error. The fact that the patient has good vision does not preclude the possibility of eyestrain causing the headache for the good vision may be the result of a compensating ciliary effort. There may, however, be occasional blurring of vision on continued use of the eyes for close work when the patient is tired or in temporary ill-health. This is due to relaxation of focussing but this clears rapidly when the eyes are rested. When there is eyestrain, there are likely to be some local eye symptoms in addition to headache, such as burning, watering of the eyes and a feeling of fatigue or heaviness in the eyes. On the other hand, eyes with gross defects and poor vision may not make the attempt to compensate for the defect and show no signs of strain.

Consideration should be given to the patient's age, use that he is making of his eyes, the illumination, and his general health and vigor. The far-sighted person who has enjoyed excellent vision for distance and near may be expected to have some difficulty in focussing near objects without glasses after reaching the age of forty. On the other hand, the near-sighted person may manage to read for years without glasses. When a patient complains of headaches and eye fatigue the physician must consider the demands made on the eyes. For example, an individual may do accounting all day, go to night school, then go home and watch television for several hours. It is little wonder that his eyes are tired the next morning. The patient's working conditions, tension, emotional stress are also factors. Not so many years ago most all the exacting visual tasks were performed only during daylight but now the eyes are often used for work entirely under artificial light. A person with excellent eyes who has been having no trouble, may develop symptoms of eyestrain

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during a period of convalescence "when they have nothing else to do but read."

Provided the eyes are normal, the conditions under which they are used are good, and the person is healthy, there is no evidence that use of the eyes is in any way harmful. Like all other organs, the eyes become tired with overuse but in general, the rational treatment of eyestrain involves the elimination of all deleterious factors in an etiology which may well be ocular, systemic or environmental.

THE RED EYE

The "red eye" is one of the most common eye emergencies. It is seen in its most dramatic form in subconjunctival hemorrhage which may be caused by a blow on the eye or may occur spontaneously after straining or coughing, etc. It is painless, treatment is unavailing, and the patient can be reassured that the condition will clear in about ten days to two weeks without harming his vision.

With the exception of subconjunctival hemorrhage, some degree of discomfort is commonly present in every case of "red eye." This may vary from mild irritation to extreme pain. It is important to differentiate between conjunctival (superficial) injection and ciliary (deep) injection, the latter being indicative of involvement of the deeper ocular structure. A drop or two of adrenalin (1:1,000) blanches out the superficial vessels and has little effect on the deeper vessels. Superficial injection may be caused by conjunctivitis (which is almost always bilateral), foreign body on the lid or cornea, and mild nondescript irritations. Deeper injection is caused by corneal ulcers, keratitis, scleritis, iritis (iridocyclitis) and by the inflammatory form of glaucoma—not by the usual non-inflammatory diseases.

Pain is present on movement of the eye with a foreign body on the lid or cornea. It is constantly present when there is a corneal abrasion. A persistent irritation, rather than actual pain, is present in conjunctivitis. The pain of keratitis

and scleritis is dull and constant, while that of iritis (iridocyclitis) and inflammatory glaucoma is more severe and generalized over the whole side of the head. A drop of anaesthetic such as Pontocain® (1½%) will immediately relieve the pain of a superficial condition but will have no effect on pain when the deeper structures are involved. Pain is not characteristic of diseases of the posterior segment, such as choroiditis, retinitis, vitreous hemorrhages, etc. However, with optic neuritis and retrobulbar neuritis, there may be some pain (usually mild) on movement of the eyeball.

LOSS OF VISION

Excluding trauma, the sudden and complete loss of vision in one eye is caused only by occlusion of the central retinal artery. Occlusion of the central retinal vein may result in total blindness but usually takes several days to reach its maximum degree of visual loss. The visual loss in optic neuritis and retrobulbar neuritis may also develop over one or more days, but usually only one eye is affected and while central vision may be lost, the peripheral field is full. Central vision may also be lost in inflammations and hemorrhages in the macular area.

The visual loss with detached retina has a characteristic onset, the patient complaining of a cloud or veil encroaching on part of his field of vision. Even before this cloud or veil is noticed, there may be flashes of light coming from the side of the eye. Similar flashes are often noticed by elderly patients who have benign liquefaction of the vitreous. The differential diagnosis can only be made by a careful ophthalmoscopic examination and equally careful visual field studies.

Acute inflammatory diseases of the retina or choroid, not involving the macula, cause varying degrees of visual blurring due either to the secondary inflammatory and hemorrhagic changes in the vitreous or to actual involvement of the vitreous. If the lesion involves the mac-

ula, there will be a central scotoma and the vision will be reduced to 20/200 or less.

Elderly patients who complain of gradual loss of vision may have cataracts, glaucoma or senile degeneration of the macula. If the ocular tension is normal, these patients should be dilated and the fundi studied. Senile macular degeneration is extremely common and is usually bilateral but not always of the same degree in both eyes in the early stages. These patients must eventually use a magnifying glass for close work. No treatment is available, but inasmuch as their peripheral fields will not become involved, it is a source of great comfort to them to be told they will never become blind.

Vitreous floaters (spots) are common. For the most part many are remnants of embryonic cells and are therefore of no pathologic significance. They may be particularly noticeable in the fluid vitreous of myopia and in elderly people who have benign liquefaction of the vitreous. In all patients who complain of floating spots before the eyes, it is necessary to rule out inflammatory diseases and hemorrhages of the posterior segment.

INJURIES

Foreign bodies on the cornea may be removed by using a sterilized needle on a hypodermic syringe. A particle of iron often leaves an embedded rust ring which should also be removed. Following the removal of a corneal foreign body, the eye should be padded overnight with some ophthalmic ointment, such as Gantrisin® or Aureomycin®, and evaluated the next day for the presence or absence of infection.

The extent of a corneal abrasion can be determined by staining with fluorescein (2%) solution.² In spite of the fact that most small abrasions heal satisfactorily within 24 hours, all are accompanied by varying degrees of pain due to spasm of the ciliary body. Relief can be obtained

by dilating the pupil with one per cent atropine (in children) or five per cent homatropine (in adults). Local anaesthetics are to be avoided as they retard epithelial healing. Infection may be prevented by the use of Gantrisin® ophthalmic ointment. Such an eye should be kept padded and the cornea stained again the next day with fluorescein. If there has not been a definite reduction in the size of the original lesion, a secondary infection should be suspected and the patient immediately started on more intensive local chemotherapy.

Lacerating wounds of the globe require highly skilled care. Both eyes should be padded, the patient placed in absolute bed rest, and the dressing not disturbed until definitive treatment is available. If the object penetrates the eye and still remains in situ, no attempt should be made to remove it unless complete and final closure of the wound can be done. Vertical lacerations of the lid require careful closure. To prevent notching at the lid margin, the skin and orbicularis are closed in one layer and the tarsus and conjunctiva closed in the other.

BURNS

The emergency treatment of chemical burns of the eye essentially consists of early and copious irrigation with tap water. There is absolutely no rationale in securing the proper chemical neutralizing solution and the delay may be damaging to the eye. Alkali burns are far more serious than acid burns and it is of the utmost importance that in addition to irrigation with water, a thorough search be made for retained particles of the alkali (lime). Should the alkali penetrate the cornea and appear in the anterior chamber, repeated paracentesis is often of value.

CONJUNCTIVITIS

Before the introduction of local chemotherapy, the usual treatment of acute conjunctivitis was limited to the frequent instillations of such preparations as argyrol followed by boric acid

² Fluorescein solution has been found to be easily contaminated with highly, virulent organisms. This can be eliminated by having the solution made up with 1:5000 aqueous zephiran.

irrigations. This simple procedure was often, and still is, quite sufficient to control the mild case of conjunctivitis.

With the introduction of numerous chemotherapeutic agents, under specific therapy, it is rare that even the most virulent case lasts longer than three or four days. Ideally a culture should be taken in every case but inasmuch as the majority clear within 24 hours, such laboratory procedures are impractical. Gantrisin® (4%) solution or Sodium-Sulamyd® (30%) solution are excellent sulfa derivatives in which local sensitivity is rare. The drops should be used every half-hour for the first four hours, then every hour thereafter. There is always the risk of local sensitivity with the use of antibiotics and the greatest offender is penicillin. In the more severe cases of conjunctivitis, Chloromycetin® solution used as eye drops has the widest spectrum. Bacitracin® and Terramycin® solutions, used as eye drops in that order, are also efficacious and safe. Drops may be supplemented by a similar chemotherapeutic ointment before retiring.

RETROLENTAL FIBROPLASIA

In 1942, Terry of Boston first described this disease which has now become the most frequent cause of blindness in infants. It is primarily a disease of the retina and vitreous and occurs almost exclusively in infants with premature birth weights of less than 3½ pounds. Fifty to sixty per cent of such infants have early manifestations of the disease while ten to twenty per cent have permanent residual damage. The disease starts with an acute onset and runs an active course which finally subsides. The final picture depends on the severity of the active stage and the extent of the fibrous tissue formed during this stage. The earliest detectable changes can be recognized with the ophthalmoscope about three to five weeks after birth and consist of engorgement and dilatation of the retinal veins and tortuosity of the arteries. There are grayish swellings of the retina in the periphery.

The vitreous becomes cloudy and new-formed (proliferating) fibrous bands extend forward from the elevated retina into the vitreous. The retrolental membrane is formed by the fusion of the vitreous bands and the peripheral folds of the swollen, elevated retina. Both eyes are affected by the disease but not always to the same extent. The active phase usually stops by the fourth or fifth month. The membrane behind the lens may be complete in one eye and partial in the other. When complete, all vision is lost.

Much progress is being made in the etiology and at present it seems likely that the high levels of oxygen concentration (50–60%) used in incubators may be the causative factor. Relatively few cases have been reported where the oxygen concentration was as low as 30–40%.³

The only treatment of this condition is preventative. Once the disease has started, no treatment will affect its course.

LACRIMAL APPARATUS

Tears are not present until about two weeks after birth. Not infrequently one or both lacrimal passages may be occluded in infants. The symptoms of lacrimal stenosis are persistent "tearing" which may be accompanied by a mucopurulent discharge. Pressure over the lacrimal sac occasionally may be sufficient to effect a passage of the stagnant tears into the nose. In general, the passing of a lacrimal probe is a relatively simple procedure and is almost always successful in effecting a cure. In small infants, this may be done without an anaesthetic but in those children over a year, a general anaesthetic is necessary.

In adults, where obstruction of the lacrimal passage may be due to infection or trauma, probing is less frequently successful and a more extensive operative procedure, such as a dacryocystorhinostomy, may be required.

³ Study of Prematures—Open Letter, Paul Harper, M.D., Maryland State Medical Journal, Vol. 3, No. 2, Pg. 55, February 1954.

CONGENITAL CATARACTS

These can be diagnosed at birth by the routine examination with the ophthalmoscope. Needling (discission) should be done at an early age, even as early as six months. This procedure may have to be repeated several times. Unfortunately, congenital cataracts are often associated with other congenital defects, such as microphthalmos, which make the prognosis poor. Disease of the posterior segment, such as retrolental fibroplasia or retinoblastoma, may be mistaken for congenital cataracts and the true diagnosis missed.

SQUINT

The ability to use both eyes together (fusion) does not develop until after six or eight months of age. After this age, the purposeless "wandering" of one or both eyes, whether periodic or not, should arouse suspicion that a true squint may exist. If one eye consistently turns in or out, the diagnosis is certain and the parents should be told that the child "will not outgrow it."

The "cover test" is the most important test in diagnosing the presence of a true squint. The child is asked to look at some test object such as the examiner's nose. The examiner's hand is placed alternately over one then the other eye. If, when the hand is shifted to the other eye, the uncovered eye moves in or out as it looks at the test object, then a true squint can be said to exist. Not infrequently, a wide nasal bridge or a slight epicanthus simulates a convergent squint. In such a case, the cover test quickly shows that neither eye moves as the eyes are covered and uncovered. This test should also be done for distant objects. If the child alternately fixes with one eye and the other deviates, it is evident that vision is equal and probably good in each eye. If one eye constantly deviates, it is practically certain the squinting eye has faulty vision and every effort must be made to force him to use the deviating eye. In general, the only

satisfactory method of doing this is complete and total occlusion of the fixing or good eye.

In all cases of squint, the refractive error should be determined at an early age. Even in infants, this can be determined by atropine retinoscopy and if necessary, glasses can be prescribed as young as one year of age. If indicated, the appropriate glass is prescribed. If there is a high refractive error, there is little difficulty in having the child wear them.

It must be strongly emphasized that the most important factor in the treatment of any squint is the building up of vision in the squinting eye. In older children, constant and total blocking off of the fixing eye is the only reliable way of improving the vision. In younger children, atropinizing the fixing eye may occasionally be successful. Surgery is indicated as soon as it is clearly demonstrated the squint cannot be corrected by glasses. The surgical correction is usually not a formidable procedure and rarely requires more than one or two nights in the hospital.

Orthoptic or muscle training is also an important adjunct in developing the ability to use the eyes together.

The psychological effect of "crossed eyes" on the developing child should not be ignored, and every effort should be made to correct the squint before he reaches the school age.

CATARACTS

An individual with cataracts complains of a gradual decrease in vision usually over a period of months. There is no known medical treatment for cataracts, the only treatment is surgical removal of the cloudy lens. Except in rare cases of hypermaturity, the optimum time for operation is elective and operation is indicated when vision has fallen below the individual needs of the patient. An eye from which a cataract has been removed will not work with an eye which has a normal lens. This is because of the difference in size of the retinal images of the two eyes. Therefore removal of a unilateral cataract

is only indicated to give an enlarged visual field on the blind side or when the cataractous lens becomes hypermature. Present day methods of cataract surgery with the utilization of corneal sutures insure tight and secure closure of the incision and enable the patient to sit up on the day of operation and to be out of bed the following day.

GLAUCOMA

Glaucoma is responsible for a large part of the world's blindness. The onset is often insidious and the disease therefore is often detected only in the late stages when irreparable damage has been done to the eye. Only about 25 per cent of glaucoma cases are symptomatic—either painful, cause halo vision or affect the central vision early. The other 75 per cent rarely complain of any visual difficulty except in the terminal stages of the disease. Thus the disease in the early stages is usually only diagnosed as a result of a routine eye examination. Only in the late stages of glaucoma does the patient discover a defect in the peripheral field of vision of one or both eyes. Each year it is estimated that 2,600 individuals become blind from glaucoma and mass screening examinations of large industrial establishments give the estimate that 2.7 per cent of individuals over 40 have undiagnosed glaucoma. There are probably over a million Americans who are unaware that they have this insidious disease.

The early case of chronic glaucoma, before changes in the optic nerve can be seen, is discoverable only by the taking of the intraocular pressure with a tonometer. Inasmuch as this is not a routine procedure, it is no small wonder that so much glaucoma exists. There would be no problem if all glaucoma patients had pain, blurred vision, or were conscious of haloes. These patients are the ones who quickly seek medical attention.

The ocular tension should be taken routinely by finger palpation. The patient should be instructed to look down but not close the eyes.

Unfortunately, this is not always accurate and it actually gives an indication of the softness rather than the hardness of the eye. Cupping of the optic nerve should make the examiner suspicious. A rough estimate of the visual field is easily done by the confrontation test although this discloses only gross defects.

The treatment of glaucoma is both medical and surgical. Preliminary medical treatment with miotics is usually indicated. Surgery is definitely indicated if, in spite of miotics, there is further loss of vision, further constriction of the visual field, or the tension is not brought within safe limits. Whether under medical or surgical regime, the earlier the treatment, the greater the chance for control and the reverse is equally true.

Acute inflammatory glaucoma offers no great diagnostic problem. The pain is excruciatingly severe and is often accompanied by nausea and vomiting. The pain is through and around the eyes. The globe is congested, the cornea may be steamy, the anterior chamber is usually shallow and the pupil is semi-dilated and somewhat oval. In such cases, the eye is stony hard. Such a case should be handled as an emergency. Pilocarpine hydrochloride (5%), augmented with eserine salicylate (1/4%) should immediately be instilled in the eye, and this can be supplemented by 250 mgm. of Diamox® orally every six hours. This latter preparation is a diuretic and has recently been found most helpful in the temporary reduction of ocular hypertension. If the pressure can be brought under control and kept within normal limits, operation had best be postponed for a few days until the congestive signs have subsided. However, if the pressure is unaffected by this local and systemic therapy, operation should be done within the first twelve hours, if possible.

Acute glaucoma can be confused with acute iritis (iridocyclitis). In each the eye will be painful to touch but in iritis the tension is normal and the objective symptomatology is quite different. Of utmost importance is the size of the pupil. In iritis it is small, particularly so when compared

with the normal pupil of the other eye. In glaucoma, it is dilated.

INTERPRETATION OF FUNDUS CONDITIONS

When evaluating a fundus, maximum pupillary dilatation is essential. The most usual dilating solution is Paredrine hydrobromide® (1%), one or two drops of this solution widely dilating the pupil in about 30 minutes. Inasmuch as there is always the remote danger of mydriatic glaucoma with any dilating drop, pilocarpine (1%) should be instilled when the examination is completed.

Provided a cataract can be ruled out, a hazy media is usually indicative of hemorrhage or some inflammatory condition. When one discovers a swollen nerve head, the ophthalmoscopic differentiation between optic neuritis and papilloedema due to increased intracranial pressure is difficult. However, in optic neuritis, the central vision is grossly impaired whereas in papilloedema, there may be no impairment of vision except in the late stages. Often one is called upon to evaluate questionable changes in the disc as an indication of early increased intracranial pressure. Hyperemia of the disc, blurred margins, a shallow cup may all be physiologic and may often exist with high hyperopia. However, in an early case of true papilloedema, overfilling of the venous tree and blurring of the upper and lower poles of the disc are probably the

most important diagnostic points. The normal ratio of the vein to its corresponding artery is 3:2 and when this is increased to 4+:2, in addition to hyperemia, shallow cup and blurred margins, there is strong presumptive evidence of the presence of increased intracranial pressure. This becomes even more so if the usual normal venous pulsation over the disc is absent.

In evaluating the retinal vessels for arteriosclerosis, the most important diagnostic points are changes at the arteriovenous crossings, attenuation and irregularity of the arterial tree, alterations in the course and calibre of the vessels. When the calibre of the arterial tree is narrowed when compared to its corresponding vein, some degree of hypertension is probably present. In later stages of arteriosclerosis and arteriolar-sclerosis with hypertension, hemorrhages and exudates in the retina are a part of the picture.

Examination of the eyes, with particular attention to the ocular tension, motility, transparency of media and fundi will be rewarding to the examiner in valuable information obtained and to the patient in terms of vision saved through early detection of disease processes.

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COMMON INFECTIONS IN THE URINARY TRACT

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In any consideration of the urinary tract, infections occupy first importance either in primary occurrence, or in complicating other conditions such as stone, tumor, anomalies, etc.

No matter where the infection starts, whether in the kidney or lower urinary tract, it sooner or later involves the entire urinary tract. The longer the infection lasts the more difficult it becomes

to eradicate and the more we may expect repeated infections. One of the chief reasons for this is the fact that the infection becomes embedded in the urinary tract and the genital system in such a way as not to be reached by drug therapy. Chronic nephritis, intramural ureteritis and, cystitis, chronic prostatitis, etc., are but a few of the chronic infections difficult to eradicate.

Acute infections of the kidney often give rise to initial symptoms of chills, fevers and sweats, similar to the symptoms of acute infections in the upper respiratory tract. Sometimes the symptoms of urinary discomforts, backache and costo-vertebral tenderness are delayed for several days and may be overshadowed by the more severe general symptoms.

Renal infections commonly occur in children, especially girls. The child may be so young that a history of urinary disturbances may be impossible to obtain and only repeated observations of the urine will suggest the diagnosis. Unfortunately when urinary tract infections do occur in children, severe and at times permanent damage is done to the kidneys or walls of the ureter, preventing proper drainage, creating a stasis of urine in a tortuous ureter and promoting a hydronephrosis, unilateral or bilateral. This damage may be immediate, or on the other hand, not be recognizable until later on in life. Pyelitis of pregnancy is occasionally due to a damaged urinary tract persistent since infancy.

Fortunately most of the bacteria that invade the urinary tract are amenable to chemotherapeutic agents. The *E. coli* group of organisms is responsible for 60–80 per cent of infections. This group of organisms may be cultured from the urine as a pure culture, but a mixed infection is usual with *aerobacter aerogenes*, *streptococcus fecalis*, *staphylococcus aureus*, and more rarely *B. proteus* and *B. pyocyaneus*.

Since many of the infections are due to the invasion by mixed organisms, recent tendency in therapy seems to indicate the administration of several different drugs at the same time. Certainly no one drug or combination of drugs is uniformly successful. Even sensitivity tests, where possible, are not entirely effective.

In persistent and long standing infections the resistance of the patient is undermined. This is manifested by low blood pressure and secondary anemia. Renal function may be so reduced by infection that a long chain of “neurotic” symptoms may develop due to an ensuing uremia.

These complicating factors should be corrected before drug therapy can be effective. Indicated drug therapy is so changeable and new drugs are constantly appearing, showing that there are still failures. These drugs are going to be more effective if the patient is put in the best possible condition generally.

The reaction of the urine is important to observe. Bacteria have to live in a favorable chemical medium. Hence if an infection persists in alkaline urine every effort is used to change the reaction and similarly acid urines are changed to alkaline urines. Some of the drugs are only effective in acid urine, e.g. mandelic acid. The use of drugs to change the urine reactions are helpful in the therapy as are proper diets.

All of the conditions of the urinary tract brought about by infections cannot be recognized by the patients' complaints. Flat X-rays and excretory pyelograms will afford a diagnosis frequently, however, since excretory pyelograms depend on the efficient functioning of the kidneys, these pyelograms may be completely disappointing, or they may suggest a diagnosis which only cystoscopy and retrograde pyelograms can confirm.

CHRONIC INFECTIONS

The relation between chronic renal infections and vascular changes is well known. Chronic pyelonephritis is considered responsible for fifteen to twenty per cent of cases of malignant hypertension. Most of the pathological processes of the urinary channels can be diagnosed either by intravenous or retrograde urography. Hydronephrosis, hydroureter, diverticulations of the bladder, etc., can all be demonstrated, but chronic infections of the substance of the kidney are difficult to diagnose at times and these are the very cases that produce high blood pressure.

CALCULI

One of the most common complications of infections in the urinary tract is the formation of urinary calculi. While it is difficult to prove the

existence of infection in every patient with renal calculi, many urologists believe that infection is present in every case and is often the cause of stone formation.

B. proteus, *B. pyocyaneus* and *B. influenza* infections, and at times *E. coli* "split urea," that is, these organisms have the power of breaking up the urea in the urine and forming ammonia. "The result is a strongly alkaline urine that favors the precipitation of the crystals of calcium phosphate and magnesium ammonium phosphate, and calcium carbonate." All these substances are present normally in abundance in the urine.

When these urea splitting organisms appear in the urine the incidence of stone is high, and stones may be expected to form regularly unless the underlying infection is eradicated.

There is hardly any infection in the urinary tract in the mature male that does not leave in its wake a secondary infection in the prostate gland and seminal vesicles. Acute epididymitis is also apt to result. While some of the prominent symptoms of chronic prostatitis are persistent backache and pains down the leg, chronic prostatitis may be, and often is, symptomless, and yet there may be sufficient infection present to cause a reinvasion of the entire urinary tract. Foci of infection such as teeth, tonsils, sinuses, cervix, chronic gall bladder disease, chronic appendicitis, in fact chronic infections any place in the body have been suspected of causing infections in the urinary tract.

SUMMARY

The vast number of infections in the urinary tract are easily diagnosed and will respond promptly to the usual treatment of mandelic acid, sulfonamides, or the antibiotics or combinations of these drugs. When these agents fail, complicating conditions may be expected and a complete survey of the entire body and more especially the genito-urinary system is needed.

Some idea of the frequency of urinary tract infections may be obtained from the following

statistics. In 1953 about 2000 cystoscopic examinations were made at the University Hospital for infections of the urinary tract. A diagnosis of urinary calculi was made in sixty of these patients. Thirty-three had stones in the kidney, twenty-three were stones in the ureter, one in the bladder and three in the prostate gland.

THERAPY

Mandelic acid and its preparations are still the drugs of choice in most of the bacillus type infections found in acid urine. The urine is almost bacteriostatic when the pH is 5.5 or below. The efficiency of this drug is enhanced by strongly acid urine. One of the best drugs in this group is mandelamine which is a combination of urotropin and mandelic acid.

The sulfa drugs are usually used against the gram-negative bacilli and all the gram-positive cocci. The sulfa drugs have now been so improved that serious reactions are rare. The administration of agents to keep the urine alkaline while giving sulfa drugs reduces reaction to a minimum. Gantrisin, or some kindred drug, is excellent.

The antibiotics are generally effective against all the infections of the urinary tract, either given alone, or even better when given in combinations. Reactions due to antibiotics are very common. Drug rash and intestinal manifestations are to be expected if these drugs are used over too long a period. In our experience, if a good result is not obtained in five days, with a specific antibiotic it is discontinued and another tried. Very often after intensive antibiotic therapy for four or five days a patient begins to have a continued or intermittent high fever from some unexplained action of the drug. It is often necessary to try different combinations of these antibiotics because of the tendency of the infection to become resistant against one therapeutic agent. For some reason there is a great tendency for organisms to become drug fast to the antibiotics and this resistance may develop very rapidly. In the use of some of these drugs a high concentration in the

blood and urine is necessary and, on the other hand, if renal function be impaired the fluid intake must be increased. Appropriate attention to the proper fluid ingestion is important.

Careful attention to the general welfare of the

patient, fluid intake, secondary anemia, diet and elimination are simple measures that should not be over-looked.

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THE MEDICAL MANAGEMENT OF ACUTE AND CHRONIC ARTERIAL OCCLUSION

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Dr. Taussig, members and guests of the Baltimore City Medical Society and the Heart Association of Maryland, it gives me great pleasure to come to Baltimore, a city famed for its medical history and for its interest in the field of Cardiovascular Diseases, and talk to you about a subject which is rapidly becoming one of the foremost problems in the field of medicine. It overlaps into all specialties, but, of course, the internist and the cardiovascular specialist meet these problems most frequently.

Peripheral arteriosclerosis is the leading problem with which we have to deal in the occlusive diseases of the extremities. Therefore, I shall direct most of my remarks to this particular aspect of the problem of occlusive arterial disease. Briefly, we might summarize some of the other problems that reduce the circulation to the extremities, but general management of all of these problems is essentially the same.

We have as another chronic progressive vascular disease affecting the young male, thrombo-

angiitis obliterans. We have the acute occlusions of healthy arteries from emboli arising centrally from the heart or the major vessels. We have the rare inflammatory diseases of the arteries which occlude them by inflammatory processes, such as periarteritis nodosa, or polyarteritis nodosa, and we have traumatic injuries to the arteries.

Kellner, in the graduate fortnight discussion at the New York Academy of Medicine in 1950, started his lecture on Arteriosclerosis with a sentence that describes the disease very clearly. He said, "It is an episodic and a segmental disease."

It is a disease of which we do not know the cause. We do not know why it flares up and quiets down, and we do not know why it involves certain areas of the body, certain segments of the blood vessels and leaves other areas immune.

Now in order to manage a disease with such a bizarre and uncertain pattern, we have to have a concept, as complete as possible, of the underlying pathology of this disease, and although I am sure everyone is aware of these changes, before I go into the problems of management, I would like briefly to review just what takes place in these arteries that we are treating or trying to manage—I think management is a better term because we do not have specific therapy.

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First, we have a change in the wall of the vessel and that change of which we are interested is in the lining of the vessel, the intima. We have a piling up of that intima so that eventually it fills most of the lumen of the vessel.

This process may take place quickly or slowly, and very frequently is limited to small segments of the vessel.

Secondly, a complication of that process is occlusion by thrombosis, and one frequently sees an acute shut-off because superimposed on the underlying pathology we have the process of thrombosis.

Thirdly, we may have a chronic process that has been present for a long time with a segment of the artery occluded by an old, long-standing, sclerotic fibrotic area with a recent thrombosis finally closing the artery. Finally, as this pathology progresses, we get recanalization to a minimal degree and we have the deposition of calcium in the wall of the vessel. This calcium as it is laid down in the wall of the vessel is a late change and not an early change, and in many of the cases the calcification is a small factor.

The cardinal signs of arterial insufficiency are rubor on dependency and pallor on elevation. When the foot is dependent, one notes typical rubor. When that foot is elevated above heart level, pallor develops.

One naturally is interested in the degree of the pulsation in these extremities and for this reason we have depended on the instrument known as the oscillometer. Certain groups, like the Mayo Clinic, are not too enthusiastic about its value while others are more so. Friedlander, in the early thirties wrote quite a monograph on the value of this apparatus in determining the type of occlusion, the level of occlusion, etc.

We have many diagnostic procedures which help us. One of the most important is the x-ray. At this point I would like to point out that x-ray evidence of arteriosclerosis, as manifested by calcification of the vessels, is no indication of the functional capacity of these arteries. In the medico-legal problems that we must face in this

field, it is common to have a lawyer or even a physician on the witness stand hold up a film with so-called four plus calcification of an artery and say that this patient can't work, can't use his extremity because his arteries are hardened, they are calcified. Actually many of these areas of calcification are limited to the middle coat, or the media of the vessel, and the lumen is still wide open. The finding of calcification makes a diagnosis of arteriosclerosis but gives us no idea of the function.

Many clinics throughout this country have done extensive work in using the arteriogram as a diagnostic procedure in routine work-up of patients. At the present time it falls into a special diagnostic procedure which is indicated in relatively few peripheral vascular problems. There are some problems, however, where it is of a great deal of value.

In order to demonstrate the site of these occlusions it is valuable to have a clear-cut picture by a contrast injection of the artery. We may find that a mass in the popliteal space is an aneurysm, a false aneurysm, or a saccular aneurysm from the wall of the artery, with the artery patent below the aneurysm and carrying blood.

With the development of the aortogram by our co-workers in South America and by much work in this country we are even able to visualize the major vessels from above the level of the kidneys on down through the abdominal cavity and into the extremities.

An arteriogram may demonstrate a segmental obstruction of arteries and reveal good collateral vessels, in which case the surgeon can be of a great deal of help to us in therapy.

So far, the pathology I have spoken about is organic. The walls of these vessels have been damaged by a process, the etiology of which we do not know, and which we have no way of arresting or altering, but associated with the organic changes we have functional changes which can be measured.

In 1926 George Brown of the Mayo Clinic wrote extensively on the vasomotor index. In

other words, he was interested in determining the ability of blood vessels to dilate whether they be major vessels or collateral. At the Mayo Clinic this was studied by the injection of typhoid vaccine and measuring the rise in skin temperature for several hours following the injection of this foreign protein. Since then we have developed simpler methods.

Landis and Gibbons, in describing reflex vasodilatation from heat, devised a method which we are using in our own clinic rather extensively and which we feel is probably the most reliable in determining the factor of vasospasm. The temperature is recorded in both lower extremities following a period of exposure of these extremities to a room temperature of about nineteen degrees centigrade. This control period usually reduces the toe temperatures to the room temperature.

During the period of emersion, when the arms are placed in hot water, we note a reflex vasodilatation and we get a temperature rise of the toes which depends on the ability of the vessels to dilate. In cases with normal vessels we obtain a rise to about thirty-two degrees centigrade. In a patient with occlusive arterial disease due to arteriosclerosis, we frequently see very little rise in the temperature of the toe tips.

This same type of graph can be obtained by doing lumbar blocks, but if you do a lumbar block, in order to compare extremities, you have got to do it bilaterally, which to a patient is annoying and uncomfortable. Therefore, we usually prefer, where we want to study one extremity as compared to the other, the reflex vasodilatation test.

On the other hand, where you are interested in only one extremity and where you have a *competent* anesthetist or a vascular assistant who knows how to do these blocks, such a block will probably give you the same information and more quickly.

In 1933 Dr. Wright and I started studying the effect of tobacco on the peripheral circulation. We noted tremendous drops in the temperature

of an extremity fingertip following the smoking of a standard brand cigarette. A few years later Lampson, of Yale, checked this work using instead of the temperature studies the platysmograph to measure changes in blood flow in an extremity.

In the basic principles of management of these people with occlusive disease, whether it be acute or chronic, there are certain factors that I would like to enumerate and then discuss in a little detail. Before pointing these out, I would like to say that I am afraid many of you will be disappointed in the negative angle of this discussion because I personally believe, and I am sure there are many workers in this field around the country who believe that peripheral vascular disease has been mistreated and overtreated to a point where the treatment has not only been useless but frequently harmful, and therefore what I am going to say will be in many instances of a debunking nature.

The management of these patients with occlusive arterial disease should have a two-fold purpose. First, to preserve the envelope of the extremity, in other words, prevent gangrene and preserve the extremity. And secondly, to improve the function of the extremity to permit better walking.

Where the disease is acute or where it has progressed to a point where the arterial circulation is so badly reduced that gangrene is imminent, we forget the second principle and go after the first. In the early case or the case which has already gone through the acute stage, the problem of increased function becomes primary.

With the first problem, the acute problem, we are interested in increasing the circulation to the skin to save that extremity. We are not so much interested in the circulation to the muscle. If you think back in your physiology, you know there is a reciprocal innervation of the blood vessels supplying the muscles and the skin.

If a dog or human is angered and has to fight, there occurs a vasospasm of the blood vessels of the skin and a secondary increase of blood in the

vessels of the muscles. Now, we are interested in the reverse problem, not in the animal who has to fight. We are interested in getting more blood in the skin, so therefore anything that you do that might increase muscle circulation is harmful for the skin and anything that you do to increase skin circulation will necessarily deprive the muscles of some of the blood supply.

In the first place, we must protect the skin. In the second place, we try to increase the blood supply to that skin by vasodilatation. In the third place, we must try to prevent thrombosis which complicates the problem of arteriosclerosis. In the fourth place, we must prevent infection. Those are the problems we have to meet in managing occlusive arterial disease.

I must point out the importance of protection, and by protection we mean avoidance of all types of trauma not only mechanical but chemical, thermal, and vibratory that tends to cut down circulation.

The position of the extremity, particularly in the acute case, is important; we are interested in what position the maximum blood flow can be obtained. Robert Wilkins of Boston within the last eighteen months has written a very excellent article in the *Annals of Internal Medicine* showing that you can get a ten per cent increase in blood flow through the skin vessels with the foot in the dependent position. In other words, an elevation of the head of the bed of ten inches so the heart is above the extremity level will increase the blood flow to the extremity. It still is a common observation as one goes around hospitals to see feet with arterial impairment elevated on pillows thereby increasing the ischemia.

I do not have to spend many minutes discussing the environmental temperature because it is an old story that where one puts heat over these extremities one increases the metabolic demands of the tissues. With the increased metabolic demands there is an increased demand for blood, and if the blood supply is inadequate you produce blistering and gangrene.

In the early management of these cases,

whether they be acute or chronic, one wants to eliminate the vasospastic factors.

I have already pointed out to you the role that tobacco plays. Adrenaline and all the other drugs of this group have to be eliminated in the care of these patients because vasospasm has to be overcome.

I would like to spend a few minutes discussing the problem of vasodilatation since it is all we hear about today, and since it is the most important method of increasing blood supply to these extremities. Moreover, there are certain vessels particularly the collateral ones that frequently have a very large element of vasospasm.

When I first became interested in this field in the early thirties, Acetylcholine was on the market. The early advertisements described it as an excellent form of treatment for Buerger's disease, arteriosclerosis, Raynaud's disease, etc. We already had at that time the nitrites and xanthenes as vasodilators. Since 1933, some remarkable drugs have been developed either acting centrally or blocking ganglia or acting on end fibers, knocking out sympathetic control so that one obtains excellent vasodilatation in the experimental animal and in the human being. Naturally these drugs were turned to in the management of cases of arterial occlusion.

I can name a few of them: Tetra-ethyl Ammonium Chloride, Priscoline, Dibenamine, Roniacol, Nicotinic acid, etc. There are more than 50 of them that are advocated as vasodilators, and many have been extensively used to increase the blood flow to the skin.

Now in the last three or four years following the work of Elkin, of Harpuda, of Barker, and others, our concept of thinking of the use of these drugs in the management of these diseases has changed. If one uses a general vasodilating drug such as Priscoline, giving it by mouth or hypodermically into the vein or into the muscle, one gets a systemic effect of that vasodilating drug which dilates the healthy blood vessels, the blood vessels capable of vasodilatation all over the body. As a result with only a certain blood vol-

ume present, you have a shift of that blood volume into those healthy blood vessels and you very frequently have, as can be shown with a platysmograph or by temperature studies or even from the symptoms, a reduced blood flow in the diseased extremity.

Therefore, I think, except in those cases where vasospasm is a predominant factor and organic disease is minimal, the general acting vasodilators regardless of how they act are contraindicated in the management of this disease when given so that they have systemic effect. Therefore, all of these drugs which have been so widely advocated and particularly pushed by the commercial houses play very little role in the management of occlusive arterial disease.

But how can we accomplish vasodilatation if we do not use them? If we can direct a blocking agent toward the sympathetic fibers that supply the skin, then we can accomplish this.

The para-vertebral nerve block is a good example of the correct approach because you knock out the vasospastic factor in the extremity in which you are interested. One does not affect the blood vessels of the rest of the body, therefore, you will have a shift of the blood volume into the extremity where you want it. The surgeons follow this naturally with sympathectomy and there is certainly a clear-cut indication for sympathectomy in these cases of peripheral arteriosclerosis where one wants to preserve the envelope, and keep the skin from becoming gangrenous.

What about the advisability of introducing these drugs into the arteries supplying the extremity? Muffson has advocated intra-arterial histamine. Many others have tried other vasodilating drugs and theoretically the approach is good. Practically, there are many handicaps which I do not have time to discuss now. There is one, though, that I would like to point out. If you introduce a powerful vasodilating drug into an artery, as an example, into the femoral artery of a leg, with impending gangrene of toes, the immediate effect of that drug is on the blood

vessels close to the area where you inject it. You open up the shunts between the arteries and the veins in the thigh and in the upper leg and you note increased heat here, but the toe where you are interested in obtaining more blood sometimes suffers for the same reason that I used in arguing against the general acting drugs. I don't believe intra-arterial therapy has too large a future role.

There is one method of vasodilatation which seems to have some value and it is the reflex method which we use diagnostically. I believe that most of the clinics treating occlusive arterial disease are using reflex heat as a part of their regime of management in producing vasodilatation. There are arguments why it would also fall in the class of general vasodilators, but from a clinical standpoint it seems to work to a reasonable degree.

The next problem that I pondered was that of the control of infection. One reason I think we are saving more extremities today is that we are better able to control infection. Infection is a big factor in the production of gangrene and in the production of localized thromboses which tend to extend.

There are a few points I would like to emphasize in the use of antibiotics in occlusive arterial disease. The organism which invades the skin may be one of many forms and we usually do not have the opportunity to culture it and find out what specific or most applicable antibiotic is indicated. There are, however, certain contraindications for some of the antibiotics, particularly penicillin, and yet I have seen more penicillin used in gangrenous, infected extremities than any other antibiotic. Our dermatological friends have shown us that there is a definite synergistic effect between penicillin and the fungi, and where one injects penicillin one frequently gets a flare-up of fungus infection with that serious complication. Therefore, the use of a wide spectrum-type of antibiotic without that aspect is indicated and we have had better success with some of the "mycin" drugs like terramycin and aureomycin.

These antibiotics have an additional side effect which many people do not think of but which should be recognized when they are used in conjunction with the anticoagulants. They sterilize the intestinal tract and reduce the formation of vitamin "K," and, therefore, they increase the prothrombin time of the blood, so that one has a mild anticoagulant effect from their use. If one is giving an anticoagulant drug and adds an antibiotic of this type, he very frequently gets a very sharp rise in the prothrombin time.

Antibiotics work best when they are given systemically so that you get distribution by blood, but because of the reduced blood supply one has to give adequate dosage since the concentration of antibiotics is naturally less because of the reduced blood supply to the part.

Local use of antibiotics has been rather disappointing. The sulpha drugs are irritating. Penicillin causes marked dermatological reactions, the "mycin" drugs perhaps less so. Terramycin or aureomycin, either in powder or ointment, or in water soluble base, seem to have some value where there is breakdown in the skin.

The final problem is that of prevention of thrombosis. When do we use anticoagulants and when do we not? Theoretically, any diseased artery is a potential site for thrombosis, and theoretically every such case should have anticoagulant therapy. However, because of the dangers of anticoagulant therapy, because of the cost, because of the duration of this pathology, it is not practical to use them in every case.

However, when one has an acute shutoff, due either to a thrombosis in a diseased artery or to an embolus, they are certainly indicated. I have seen a thrombus progress from the popliteal artery to the femoral artery in two hours and twenty minutes, and if heparin had been used in that particular case, it might have been prevented. But there is another reason to use anticoagulant therapy in these cases of acute shutoff and that is, they are frequently and seriously complicated by secondary venous thromboses. One often loses an extremity because of this com-

plication and also one occasionally loses the patient because of embolism from the veins.

Therefore, any patient with an acute occlusion, while he is bed-ridden, should receive anticoagulant therapy. Any chronic case, which reaches a point where he has to be put to bed, should receive anticoagulant therapy during the time he is in bed, not only to prevent the development of arterial thrombosis but also to prevent the complication of venous thrombosis.

Now I have spoken most emphatically about the acute problem because that is where we concentrate our efforts, but we still have the individual who comes into our office because he can only walk a block. What are we going to do to increase the muscle blood supply? We are not interested in the skin in this individual. We want to get him so he can play his eighteen holes of golf or carry on his work.

The vasodilating drugs, if we follow my reasoning already presented, certainly are not going to increase walking distance. Unfortunately patients often report subjective improvement to almost any drug.

We have carried out double blindfold tests on all types of substances which are supposed to reduce claudication and have been convinced they do not do it. If we do a sympathectomy on these individuals we divert the blood from the muscles; we dilate the blood vessels of the skin and with the blood supply available more of it goes to the skin and less to the muscles. It is a frequent observation that after sympathectomy, one has a shorter walking distance than before the sympathectomy. Some of my surgical friends like to argue with me, saying that in the long run a sympathectomy will decrease claudication; at six months or a year later these people are walking further, two or three times further.

My answer is that if you take a man with arteriosclerotic disease and give him one simple piece of advice he will be walking just as far a year later as the fellow who has had a sympathectomy. That advice is to use his extremities within his tolerance. In other words, the best method I

know of that we have available today to develop collateral circulation to muscles is the use of these muscles.

Some of the workers of this field have overdone it. They have urged these people to go to extremes in exercise. If you use a muscle with ischemia, in the first place it won't work and in the second place you may develop a thrombosis in some of the vessels supplying it. We see cases of acute shutoff, where a patient with intermittent claudication tried to catch a train or where he pushes himself to a point where he practically collapses. He then may find that, instead of walking a block, he can only walk ten feet since he has thrombosed an artery in his efforts to use the extremity with improper blood supply. On the other hand, if you teach these people to walk slowly, to walk frequently, and to use their legs as much as possible, they will develop improved collateral circulation.

I have made many friends over the last few years by telling patients to get back to the game of golf after they have been advised by some

other physician that, because they have arteriosclerosis, they should quit playing golf. These people, at the end of a year, are frequently going eighteen holes without trouble where they couldn't get through nine in the beginning.

If these individuals do not use their muscles, they go on to atrophy and there will be no stimulation to the development of collateral circulation.

Mechanical aids have been used, such as the suction pressure boot, the oscillating bed, and intermittent venous occlusion. They all play a small role in the management of the acute and chronic case but each one of these mechanical modalities of therapy works best in the hands of those who devised them and who have trained technicians who know the details and the dangers and the complications of their use. Therefore, most of these modalities have been dropped. The oscillating bed probably has stood the test of time better than any of the others.

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THE SHOULDER GIRDLE SYNDROME

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Attention will be directed tonight to the shoulder girdle syndromes, particularly as related to arterial flow, and only incidentally as related to neurological signs and symptoms and to venous obstructive phenomena.

The subclavian and axillary artery pass through a narrow bony passage invested with muscles and similarly the subclavian and axillary vein return through the same structures. The brachial plexus, however, is spared for the most part except for the two lowermost pathways of C8 and T1.

Anatomical structures that are important to

both the artery and the vein are: One, the first rib. (This is aggravated in the occasional case when a cervical rib is present.) Two, both of these vascular structures must pass the scalenus anticus muscle, the artery behind it and the vein in front of it; three, they go behind the clavicle and four, underneath the pectoralis minor muscle, and five, the artery passes through the two cords forming the median nerve. At any one point or at several points, impingement may take place.

Historically, although the cervical rib was recognized as a syndrome as early as 1860, it was not until 1905, that Murphy observed neurovascular changes due to pressure between the cervical rib and the scalenus anticus muscle.

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Naffziger and Grant, followed by Ochsner, Gage and DeBakey, pointed out that you could have the same symptoms without a cervical rib due to pressure from the scalenus anticus muscle.

In 1943, Falconer and Weddell pointed out that without organic disease of the clavicle or the first rib, one could have postural abnormalities with pressure on the vessels by the clavicle approaching the first rib resulting in the costoclavicular syndrome.

Finally, Dr. Wright in 1945, described the hyperabduction syndrome wherein the arm in the position of hyperabduction due to work or sleeping or otherwise could interfere with the arterial circulation to the hand and lead to gangrene. Recently this has been pointed out to be due largely to pectoralis minor pressure.

The symptoms will depend on which of these syndromes are in effect, and on the structure they are pinching. The symptoms may be those of arterial ischemia in any position, or perhaps only upon assuming certain positions. They may be due to venous obstruction of an intermittent nature or complete in the form of thrombosis with edema, cyanosis, and heaviness of the arm with distended veins.

The neurological signs will be entirely limited to the ulnar nerve distribution in the hand and forearm.

We have focused our attention almost entirely on the arterial phase. Accurate diagnosis is the most important single point in the whole management, and from the arterial point of view it is relatively clear-cut. Surgical therapy follows simply. Cervical rib, of course, is usually a roentgenological diagnosis. A patient operated on recently at Bellevue entered the hospital, curiously enough, for rectal bleeding, but our residents, leaving nothing unturned, found out that the rectal bleeding was simply due to hemorrhoids, but much more excitingly, she had a partial paralysis of the ulnar nerve. Therefore, she was studied more carefully and suspected to have a large cervical rib. X-rays confirmed it, just as Murphy pointed out many years ago. The roots

of C8 and T1 were elevated significantly, and after removal of the rib, they fell downwards. The artery was also fully released. Immediately, postoperatively, on awakening, her hand felt better.

In the four years we have been studying these various syndromes, only twenty cases have come to operation. The vast majority—this is particularly true of cervical ribs—are non-surgical and most often are not even symptomatic and require no therapy.

The scalenus anticus syndrome is the one we have steered most clearly away from. First of all, when they are purely neurological, they have usually been seen by the neuro-surgeons and not by ourselves. We have operated in the last four years on the scalenus anticus syndrome only in two cases.

The method of demonstrating the scalenus anticus syndrome is to adduct the arm to the body and observe the radial pulse. For example, a patient I saw today in the office, operated upon a year ago, pre-operatively had an imperceptible blood pressure in the left arm in adduction. When the arm was elevated to ninety degrees, the blood pressure reappeared, and the oscillographic reading was normal. She also had neurological symptoms in the distribution of the ulnar nerve and following scalenus anticus section has done well, both from the vascular and neurological viewpoints.

The demonstration of the costoclavicular syndrome is best illustrated by our Chief Resident at Bellevue who completed his training four years ago. He was an air force pilot and was unable to keep a parachute strapped to his back. When he would assume the "West Point position" with his shoulders back, the radial pulse on the left side disappeared completely. When he was relaxed and slumped as a typical surgeon does, and I'm a good example, his pulse would then return in full strength and his blood pressure would be normal. Whenever he would thrust his shoulder back into the usual proper stance, the clavicle would press on the subclavian artery

and completely obliterate it. He was unable to keep a parachute on his back, having to remove it as soon as it was possible to do so without being observed. As a surgeon, of course, he is in an excellent occupation, having no trouble slumping forward. Whether he will have trouble in the future and have an arterial thrombosis, I do not know. On the basis of our present experience, I predict that as he reaches the fifties, he will have a thrombosis of his subclavian artery and would probably be better off with the procedure which I will describe. In the meantime, however, we are not on sure enough ground to recommend such a prophylactic procedure.

The costoclavicular syndrome, therefore, is demonstrated by having the patient stand erect, and thrusting the shoulders back and downward as though he were carrying two heavy buckets of water. The radial pulses are palpated during this maneuver, and if they obliterate, it is suggestive that the narrowed costoclavicular space may be the cause of the patient's ischemic symptoms.

The hyperabduction syndrome is demonstrated by elevation of the arm well above the head. In that position in approximately a third of all normal people, the radial pulse becomes much feebler, and after holding that position radial pulsations may return to a moderate degree. In a small percentage of asymptomatic people the radial artery can be demonstrated to remain completely obliterated as long as such a position is maintained. Such individuals, if they make a habit of sleeping in a position of hyperabduction for long periods, or of working in that position, for example grease pit mechanics, and painters who have to paint well above eye level, as well as telephone operators where the plugs are above their heads, will develop serious trouble due to ischemia.

Approximately nine out of ten patients with manifestations of these various syndromes can be managed on conservative measures. Representative of this group is the hyperabduction syndrome. The first patient Dr. Wright saw was an individual with an obscure gangrene of the

tips of his fingers and all that was found was that he was sleeping regularly in a position with his arms behind his head. When that fact was recognized and there was no arterial occlusion, no venous occlusion, no Buerger's phenomena, etc., treatment consisted simply in tying his arms so that they could be elevated only a few inches during sleep. The whole chain was broken and eventually his fingers returned to normal.

The costoclavicular syndrome can be counteracted as I mentioned previously in the example of the surgeon who simply avoided the erect posture. Dr. Huebner had a patient who was overweight and who had large pendulous breasts. Her brassiere pulled strongly down on her supraclavicular area causing obliteration of the pulses, and by simply changing the type of brassiere to an uplift one, and with weight reduction, she was relieved of her symptomatology.

About half the patients we have operated upon have not only had intermittent blocking to the arteries, but have also gone on to develop complete arterial thrombosis. The group of patients who had thrombosis have done well on measures designed to create space where the artery arises from the intrathoracic region to the axilla eliminating all points of pressure, either bony or muscular.

One of two patients we operated upon at Bellevue Hospital recently had had a thrombosis of her subclavian artery following childbirth. The reason was unknown except that possibly she was sleeping in a position of hyperabduction. The thrombosis led to marked ischemia of the hand and when seen at Dr. Duryee's clinic at the University Hospital about six months later, she still had all the signs of marked arterial insufficiency.

Operation disclosed that the block had occurred in the subclavian artery at the medial border of the scalenus anticus muscle. Attempts to restore continuity were not carried out because of the extensive length of the thrombosis. However, a procedure which I will describe was utilized.

When the hyperabduction syndrome is a pure and isolated phenomena, then an operation designed by Dr. Fred Cooper of Atlanta has been singularly successful. He has had three patients who have had good results with a "follow up" for over two years. We have had three who have done well for a period of one year, one month and one week respectively. These patients have had marked obliteration of their pulse on abduction to ninety degrees or beyond. They have had no thrombosis and good pulses are present when the arm is by the side. Section of the pectoralis minor muscle, a simple procedure to perform, has been uniformly satisfactory.

The first patient in whom we carried out this procedure of making room for the vascular structures was a woman who had congenital double clavicles bilaterally. There was non-union in the mid-portion, however, the clavicle had never been injured. She developed arterial thrombosis of the left subclavian artery at the age of forty-five, and at the age of fifty thrombosis of the right subclavian artery developed. She had marked evidence of arterial insufficiency and absent oscillometric swing in both arms. She was operated upon by removal of both segments of the right clavicle, section of the scalenus anticus muscle and mobilization of the subclavian artery downwards. The thrombosis was lateral to the scalenus anticus muscle. Following this procedure, the pulse returned within one week and we then went ahead with the procedure on the other side which had thrombosed five years earlier. The left side improved. We were therefore led to the concept of developing room in this area on the anterior side rather than attempting to remove the cervical rib or trying to develop room posteriorly. The beneficial result was obviously an improvement in the collateral circulation due to the elimination of mechanical pressures.

We have done this operation now on some thirteen patients comprising seventeen extremities over a period of three and a half years. It is evident that it has not been applied frequently, but it has been uniformly successful when arte-

rial involvement has been paramount. In one patient where there were only neurological symptoms of a vague nature, we regretted carrying out the procedure because it did not afford relief.

The operation, in outline, is to expose the clavicle and resect it subperiosteally in toto. Elkin and Shumacker have described the removal of the clavicle for blood vessel exposure, and the late Dr. Frazer Gurd, of Montreal, wrote some fourteen years ago that in his experience the clavicle could be sacrificed without any serious disability. In the seventeen extremities operated on, we have not seen any disability except for two heavily muscled men who have subjective complaints of aches and fatigue in the pectoralis major muscle. Perhaps in the latter isolated type of patient, a heavily muscled man, it should be considered with some seriousness.

In the first two patients having normal clavicles, we made room by removing the middle half of the clavicle leaving the lateral and medial quarters and dividing the scalenus anticus and mobilizing the artery downwards. To our chagrin, in a period of four or five months the clavicle regenerated and led to a return of symptoms. We had to go back and remove the regenerated part of the clavicle plus the lateral and medial segments and the periosteum.

After the first three patients, the operation became a planned procedure wherein the clavicle was removed totally subperiosteally and the periosteum was excised so there could be no regeneration. With this procedure there has been regeneration of only one clavicular segment in one patient, about an inch long laterally. We obviously missed some of the periosteum. In addition the scalenus anticus muscle is located, isolated, and the phrenic nerve retracted. After the muscle is divided, its ends usually retract. This effects good exposure of the brachial plexus and the subclavian artery which can be mobilized down after freeing it from the surrounding structures. We have not divided any of its branches.

Even though there has been thrombosis in this region, either proximally or distally, this proce-

ture has been followed in each instance by an improvement in the arterial circulation to the arm with usually a normal oscillometric index ensuing eventually. The three reasons we believe it helps is that 1) it eliminates all pinching in the scalenus anticus region whether there is a cervical rib present or not. 2) It eliminates any possible pressure between the clavicle and the first rib, a space which in some of these patients is extremely narrow. It eliminates pressure between those two structures as well as pressure on the subclavian vein. 3) It permits the shoulder, after the clavicle is removed to fall inward towards the thorax, also it lengthens the artery relatively and hence eliminates pinching behind the pectoralis minor muscle.

Function is unlimited and there is no obvious physical deformity. The only thing they can do is that old trick of bringing the acromii forward and having them meet.

Two interesting cases are cited briefly: A graduate nurse was operated upon approximately two and a half years ago. She had a large cervical rib on the right side and had developed intermittent fatigue of the arm when she used it. Typing became harder to do and Raynaud's phenomena of the fingers were noted. Finally she came to the point where she could not use her hand. She was examined by Dr. Wright who found the radial pulse reduced in volume and the oscillometric swing subnormal. In certain positions the blood pressure was almost equal to the other side. Ten days after his observation and after I had seen her in my office prior to admission to the hospital, she developed a complete thrombosis of the subclavian artery. At operation the cervical rib and the scalenus anticus muscle were found to be pinching the artery so that it was almost pancaked. Distally there was a fusiform aneurysm about seventeen millimeters in diameter and beyond this point the artery was thrombosed due to the narrow area between the clavicle and the first rib. She was subjected to claviculectomy and section of the scalenus anticus and now is in exceedingly good condition.

Her Raynaud's phenomena have cleared in all but one finger. The radial pulse is normal in both arms and she is able to work full time.

About four months ago we had a patient who in 1927 (she is forty-two years of age now) sustained a bilateral fracture of the clavicle in an automobile accident. Malunions resulted, and, therefore, open reduction of each clavicle was performed. Good union occurred on the right side, but on the left side nonunion with overriding occurred. This did not bother her from 1927 until the summer of 1953 when she noted an increase in the size of her left arm. Measurements confirmed the enlargement. The superficial veins were distended. It was clear that she had had a subclavian vein thrombosis. That was not too serious until suddenly her artery began to be pinched and she lost the strength of her arm. An X-ray showed nonunion with overriding of the clavicle with the distal segment pointing inwards and downwards. At operation it was seen to be pressing firmly on the subclavian artery. Following its resection the artery pulsed normally and the arm could be moved in all directions without limitation. The patient is now four months postoperative. She has a good result following simple resection of both ends of the un-united clavicle.

At the present time we reserve the complete operation for patients with the costoclavicular syndrome when combined with either the hyperabduction or scalenus anticus syndrome. If the scalenus anticus is alone responsible, we section it and nothing more. If the hyperabduction alone is responsible, we section the pectoralis minor.

In summary, the two points I would like to emphasize are, (1) surgical intervention for the shoulder girdle syndrome is not commonly necessary. In four years we have operated upon only twenty patients. Secondly, if the diagnosis is not accurate, many bad results will be seen by using operative measures. That has been seen with the indiscriminate sectioning of the scalenus anticus, and it has been very disturbing. Unless these pa-

tients are diagnosed accurately and first have good medical management, we are going to fall into many pitfalls. On the other hand, as in many other fields of medicine where surgical therapy plays a significant role, accurate diagnosis based on a careful analysis of the patient's

symptoms and signs is the most important factor. Accurate diagnosis will in turn lead to the selection of the correct surgical procedure and hence to worthwhile results.

55 East 92nd Street

New York 28, New York

QUESTIONS AND ANSWERS

DR. FORT: Thank you very much, Dr. Lord and Dr. Duryee. Our speakers would be very happy to answer any questions. Dr. Loughrie will have the portable mike and if you care to he will hold it to you so that you may ask questions.

Q. Have any exploratories been done in cases where the diagnosis cannot be established from "lab" or clinical test?

DR. LORD: I feel you must be on absolutely rock-bottom ground of peripheral changes in the artery. That is, you must have evidence of arterial impairment, either intermittent or complete before you consider an exploratory in this region.

As Telford, who probably is the leading student of this subject in England, pointed out, one should be prepared to really look in this region and not have too many preconceived notions. Fortunately except for section of pectoralis minor, all of the procedure in this region can be carried out through the same incision. Therefore in that sense one can carry out an exploratory procedure. I would never carry out an exploratory operation in this region for symptoms in the hand without absolute objective evidence of arterial, venous or neurological changes. It should not be done for subjective pain without confirmatory objective signs.

Q. To what extent do you use anticoagulants post-operatively?

DR. LORD: I think the philosophy of using anticoagulants in general and in my own personal experience, is similar to that of Jahnke and his associate, Seeley and others with their military experience in arterial injuries and aneurysm and fistulae, namely, not to use them. The only

exception in this group of cases is in one patient, I think the one I cited but didn't show you the slide, had an aneurysm and arterial thrombosis, as well as a previous deep vein thrombosis. She developed a new thrombosis postoperatively of a superficial vein in the neck which we had divided, and we felt that she might get into more serious venous trouble so we put her on anticoagulants postoperatively. That would be the only indication, I believe.

Q. I wonder if Dr. Duryee can mention something about the use of alcohol in the treatment of peripheral vascular diseases?

DR. DURYEE: I do not have any statistics as to how many drunkards we have made in this field, but I am sure we have made a few. The use of alcohol as a therapeutic agent has been long advocated in the medical management of these cases. I am not sure how it works. If it acts as a vasodilator then my theory of a general acting vasodilator would contraindicate its use. I think it has another action.

Alcohol, as most of us know, sort of releases some of our tension, and I think a great deal of the relief we get with alcohol is a mild anesthetic effect and released tension. I'm not too sure it is of great value in the management of these cases.

Q. I'd like to ask Dr. Lord his point of view toward lumbar sympathectomy in arteriosclerotic peripheral vascular disease. Is he as "on the fence" about it as Dr. Duryee was?

DR. LORD: I think the nicest thing that I have had said about me was said by Dr. Duryee earlier in the evening, that I was one of the surgeons

who thought a little bit medically. This is to me the epitome of all compliments. But frankly, I feel exactly the way he does, I think lumbar sympathectomy is the most over-rated operation ever developed except that it has real value where there is some degree of vasomotor tone. I don't think it makes any difference whether there is Buerger's disease or arteriosclerosis or Raynaud's. If you can demonstrate some degree of vasomotor tone and you are not getting where you want to on medical measures, then lumbar sympathectomy or upper thoracic sympathectomy is an excellent procedure. But to do it when there is no vasomotor tone demonstrable, as many of our confreres, particularly surgeons, have emphasized throughout the country, then I have not seen any magic from it. Our residents at Bellevue and Gouverneur Hospital are just as happy to operate on a patient as they are most every place else. Lumbar sympathectomy is a nice, clean, decent operation to do and therefore we have had to restrain them rather vigorously, but I think they agree too, that it is a useless operation when there is no vasomotor tone. I think it is a question whether there is some vasomotor tone. As Dr. Duryee has pointed out in using the Landis test or using the paravertebral block we always test that first unless clinically it is obvious that they have vasomotor tone, as in an aneurysm. When you are going to do a Matas' oblitative endoaneurysmorrhaphy routinely do a lumbar sympathectomy before or complimentary to doing a Matas' procedure. For the type of patient Dr. Duryee is talking about I don't think we have done a dozen cases in four years on our wards or in private practice altogether.

DR. DURYEE: I would like to elaborate on this question. I'm sorry if I left the impression I was "on the fence" because I have some pretty clear-cut ideas and they could be summarized very briefly. One is that you do not do it for intermittent claudication. Two, you do it only where you want to increase the blood supply to the skin and you do it only in those cases, as Dr. Lord has

pointed out, where one can demonstrate that you will get a better blood supply to the skin if you do it.

Q. Would you describe the reflex method of treatment of peripheral arterial disease?

DR. DURYEE: The method we use is simply the application of heat to the upper part of the body. Where one has the usual common problem of a cold extremity with arterial occlusive disease with perhaps some rest pain after the patient goes to bed, we apply an electric pad or hot water bottles to the upper thigh, lower abdomen, or across the back, leaving them on for long hours at a time. Actually some of these people sleep with an electric pad over their lower back or abdomen or thigh. Keep the heat as a reflex heat and never in direct contact with the ischemic tissue. In some cases where the amount of blood flow is markedly reduced and there is constant rest pain, we use several hours of immersion of the arms in water at one hundred ten degrees, exactly the same thing we do in the reflex test.

Q. What is your feeling about the use of endarterectomy or segmental resection in thrombosis of the femoral artery of the lower extremity?

DR. LORD: We have had bad luck with treatment of popliteal and femoral occlusion. We have had better luck with the aorta and iliac artery. We may have stumbled on something the other day but like the murderous significance of a single case one shouldn't draw conclusions. Our problem has been that we have only done patients who have had gangrene and were going to lose their extremities, some nine or ten patients, and we have had our problems with endarterectomy. Everything is fine at the upper end. Dr. E. J. Wylie last year at the meeting of the American Heart Association stated that at the upper end wherever one starts the endarterectomy, he dissects the intima and the thrombus, and when he reaches the lower end where the vessel is patent, he bevels the intima like a ski jump, but we have never been able to do that.

The intima has to start where you have

stopped your endarterectomy, and we have tried mattress sutures to tack the intima to the media, but it has probably failed to prevent dissection. We learned something quite by accident, and it may be significant or it may not be. There was a thrombosis of ten years' duration in the external iliac artery and a two week old thrombus in the common iliac that had led to impending gangrene. On dependency the foot showed marked rubor and a thirty-five second venous filling time. We exposed the entire common and external iliac artery down to the femoral. We exposed the femoral artery first to prove it was patent and didn't do an aortagram because I have observed more trouble than good from some aortagrams. After demonstrating its patency, the incision was carried upwards and then it turned out we had to take a seventeen centimeter segment out, and there was no graft that long in the arterial bank. So what we did was to do a nine centimeter thrombo-endarterectomy from the common iliac down to the inguinal ligament and then we removed eight centimeters of the common and superficial femoral artery and put the graft in at that point. . . . So we had a nine centimeter endarterectomy with the thrombus out and then an end to end anastomosis between the resutured vessel and the graft and also to the distal femoral, with a nice intima to intima approximation. We did not use anticoagulants on him. He went home about two weeks postoperatively with good pulsation below and a good foot.

We therefore use thromboendarterectomy from the terminal aorta to the upper superficial femoral artery with or without a vein or arterial graft.

Q. There are circumstances which arise where the envelope as well as the muscle ischemia is present. In those equivocal circumstances would you be obliged to recommend sympathectomy or would you be obliged not to recommend sympathectomy?

DR. DURYEE: You rarely see gangrene, primary gangrene, of muscle. You frequently see it of the skin and if the ischemia is advanced to a

point where you are afraid of gangrene, possibly losing the extremity because of that, I'd be in favor of sympathectomy providing, as I said, we could demonstrate some vasomotor index. George Brown said you had to get a six degree rise in temperature before you do a sympathectomy and Dr. Addison working with him used that measurement. I think that is a little liberal. If we get a rise of even two or three degrees, we'd go ahead and do a sympathectomy on that type of case.

DR. FORT: Are there any further questions?

If there are no further questions I think it would be very nice to ask Dr. Trimble to say just a word.

DR. I. RIDGEWAY TRIMBLE

I was afraid I wouldn't have an opportunity, Dr. Fort.

First of all I would like to say how much I enjoyed Dr. Duryee's and Dr. Lord's presentations here tonight. We, in Baltimore, are quite interested in peripheral vascular disease.

Now just before the war down at Baltimore City Hospitals, a number of us here tonight became interested in it. George Yeager and myself, and others who were working with us, became interested in some of these older men down there who had lost one leg, and you know a man who has one leg remaining can get along pretty well but when he loses both he is pretty helpless and destined to a life in bed or in a wheel chair.

So we decided to do something for these men and began with sympathectomy on the side of the remaining leg, even though the index of improvement after block or after reflex warming was not great. Up to that time the index had to be great before sympathectomy would be done.

We found to our gratification that many of our most favorable responses were in those cases in which the preliminary tests were not encouraging. It may be because you cannot block the sympathetic function as well by test as you can by dividing the trunk.

I think it is perfectly true that they are pa-

tients in which sympathectomy is contraindicated. On the other hand there are two reasons why we do sympathectomy. One is to improve the walking distance, as has been said, to improve the function of the limb. The other is a prophylactic measure, to improve the circulation of the skin, subcutaneous tissue and muscles as a prophylactic measure against gangrene developing at a future time. I have many patients active and comfortable after sympathectomy done 5 to 15 years ago who without sympathectomy would now be amputees. So we tell these people there is two-fold purpose for our operation.

Now, you are going to hear more and more about the replacement with arterial graft when that is feasible, and it will become more feasible as our studies in the arteriography become more developed. Nevertheless sympathectomy in a great majority of cases is in my opinion strongly indicated and I have operated on very many cases where the walking distance is increased.

I was rather much surprised to hear that Dr. Duryee is not using it in those cases.

I do think if you have no pulses in the pedal vessels and the popliteals, even up in the femorals, then sympathectomy may not help their walking distance. But if you have some pulses still present or if you have even good femoral pulses present, many of the patients will tell us they can walk as far as they want to within reason. Others will tell us their pain, their cramps, have been changed, substituted for by a tired feeling after walking a certain distance but they are eternally grateful not to have cramps. Practically all of them can walk a greater distance and I don't think it is a greater distance because of walking more slowly, although I heartily agree with Dr. Duryee about keeping patients mobilized.

Finally, I would like also to agree with him on his treatment of infections and recommend for your own interest some work that was done here by Dr. Classen, who is here tonight, on the treatment of infections in the extremities by the sim-

ple remedy of combatting the epidermophytotic infections about the toes by immersing the feet in potassium permanganate solution. We find that that simple remedy in so many of these patients will heal the lesions, and will improve them so far as rest pain is concerned. The fungus infection plays a great part in starting off this train of events. I'm sorry we didn't hear more about the direct approach to the arterial grafts on this problem.

Last of all I would like to ask those present to bring the patient with acute arterial occlusion to the surgeon more quickly. Many of us have seen results that are terribly disappointing when the patients are brought too late, but recently we have had a patient of Dr. William Pierce with a saddle embolus at the base of the aorta, and operated on her three hours after the event occurred. We were able to remove the saddle embolus from the aorta; and instead of developing bilateral gangrene of her legs assuredly and dying, she recovered perfectly.

Another case was just recently successfully operated three hours after onset with a brachial artery occlusion. It is generally recognized in these cases that if the period of six hours has elapsed before they are treated surgically, we can do very little for them.

DR. FORT: I think it would be very nice at this point for Dr. Yeager to talk to us.

DR. GEORGE H. YEAGER

I have very little to add to what has been said tonight. I share Dr. Trimble's comparative enthusiasm for sympathectomy. I am perfectly willing to agree that it must be a selective procedure and that some patients may be harmed by it. However, I do not believe that all patients have to have a demonstrable degree of vasoconstriction expressed in two, three, or four degree centigrade of vasospasm, to justify the operation.

At this time, we have no completely accurate method of determining the vasomotor index. Paravertebral block, as performed in the average clinic in testing these individuals, is a pretty in-

accurate study. It is an infiltrative procedure fraught with many potential errors.

I believe that all patients should be thoroughly evaluated from the viewpoint of sympathectomy, and certain cases should be screened out.

Dr. Trimble has referred to some of our City Hospital patients. Many of those patients have border-line viability of their surface structures. Le Riche coined a phrase of "self-sympathectomy." Such an entity is seen in many sclerotics. Nevertheless, when one is dealing with a crisis, such as a breakdown in the viability of the epithelium, one, two or three degrees rise of temperature may become very important. Many times these patients will obtain subjective relief.

I was particularly interested in Dr. Lord's reference to the shoulder girdle syndrome. I would like to know whether he has seen venous thrombosis in this entity.

Some years ago, Dr. J. A. Kirtley advocated almost an identical procedure for spontaneous axillary thrombosis, such as seen in the emphysematous type of individual. He combined it with a very extensive supraclavicular dissection in which all the surface fascia was excised.

I would like to hear Dr. Duryee discuss his use of Buerger-Allen exercises.

FURTHER DISCUSSION

DR. LORD: It's mighty unfair to come to a City and take away all the surgeon's business by saying it's no good. I frankly think sympathectomy is a very valuable operation and it should be done. However, only in selective cases where there is evidence of vasomotor tone.

As George Yeager pointed out, it doesn't always follow that a rise in temperature is necessary. Occasionally one will get a good blood flow postoperatively in spite of the absence of temperature change in postoperative testing.

Frankly, I like to use not just a skin temperature but rather use the appearance of the foot. Now the foot is a little moist, the veins are collapsed, there is a little cyanosis and you do a paravertebral block or do a Landis test. The foot

becomes pink and the veins dilate, the foot becomes dry, and you have evidence of vasomotor tone. You don't have to have a rise in temperature. We have had several cases at Bellevue and some in private practice without any rise in temperature using the ordinary thermocouple and the constant temperature room, who have done well after sympathectomy. If you have no improvement in color, no rise in temperature, if you have no filling of the veins or they are already partially filled, in dependency and they are collapsed at heart level, I have never seen a sympathectomy have a favorable effect. Although I have the most immense respect for Dr. Trimble who pioneered this field in his original articles back in 1939-1940-1941, we have done this at Bellevue which is a hospital exactly like the one at Baltimore City Hospital and in the same class of patients. We have also done it in private practice while exploring its limitations. Where there is no vasomotor tone we have not had good results. But vasomotor tone does not have to be based on a four to six degrees temperature rise, it can be based on the things I have just mentioned.

In regard to Dr. Yeager's question about venous thrombosis, about half of our patients of the twenty operated upon (there were about twenty-six limbs in all), have had venous thrombosis in their background. Any procedure we have done has not improved the venous thrombosis per se. It has gone its merry way which has usually been marked improvement over a period of time, with elevation or wearing an elastic sleeve like an elastic stocking. The operation has not made it better nor has it made it worse.

I am familiar with the operation of Dr. R. S. McCleery and Dr. J. A. Kirtley and their associates. Frankly, I have not applied it. We believe our procedure does the same thing but as I say it does not have any favorable effect nor deleterious effect on the venous thrombosis.

DR. DURYEE: Just as a last stab at this prob-

lem of sympathectomy for claudication, I am going to make a plea instead of a statement.

We need to have somebody develop a good objective method of measuring exercise tolerance. I agree one hundred per cent with Dr. Trimble that for the preservation of the limb, and in these people with one leg off and with the possibility they may get a breakdown and gangrene in the other extremity, sympathectomy is definitely indicated. The problem of its use in intermittent claudication I still think is an undecided one, and in order to decide it somebody has to develop a treadmill or some type of apparatus to actually demonstrate whether these people have a better blood supply of the muscles after sympathectomy.

The radioactive isotopes are our hope and they may still be the answer but so far we have been unable to develop any satisfactory system measuring muscle blood supply. Princemetal, Elkan, Quimby, etc., who have used them, haven't developed an accurate method of measuring the blood flow to the muscle. You can do it to the extremity as a whole but to differentiate the subcutaneous tissue and the skin, etc., hasn't accurately been done to date.

Now the final question, Dr. Yeager, is about the use of Buerger's exercises. I said in my dis-

cussion that the only mechanical gadget that has stood the test of time is the Saunder's bed and I believe that the passive use of Buerger's principle of elevation and dependency on this bed where the individual doesn't have to use his muscle in the advanced case with impending gangrene with rest pain, is of real value providing that bed is adjusted to the individual so that no long periods of ischemia develop during the cycles.

Now as far as the active use of Buerger's exercises is concerned, I believe in the majority of cases one can accomplish as much by just having the patient walk within his tolerance.

There is a borderline group where the walking distance is very short, where there is no impending gangrene and claudication is the only symptom, where perhaps the active Buerger's exercises help. However, if one follows the work of Wilkens and measurements of blood flow in the leg in various positions, probably simple elevation at the head of the bed with dependency will do almost as much.

DR. FORT: Are there any further questions?

Once more I would like to thank both you gentlemen for coming to be with us and your time and efforts in our behalf.

Meeting adjourned.

SELECTIVE SERVICE RESUMES PROCESSING OF PHYSICIANS

The AMA Washington Letter, No. 65

For the first time since last August, local draft boards are again processing physicians for induction under the Doctor Draft act. Selective Service headquarters on March 25 ordered draft boards to resume processing for physical examination and induction of priority 1 and 2 physicians of all ages, priority 3 physicians born after August 30, 1922, and priority 1, 2, and 3 dentists of all ages. Selective Service explained that it expected at any time to receive an armed forces call for physicians. Calls for dentists in March, April and May already have been allocated to the states.

The government halted drafting of physicians last summer after the Korean truce and a high percentage of young physicians entering the service on completion of their internships had produced a large reservoir of medical manpower. The last call for physicians was for 542 in August.

ARTICLES OF INTEREST

DOCTORS' DAY¹

ARCHIE ROBERT COHEN, M.D.²

Speaking for the physicians of Washington County, we are happy and proud that the Governor of our Great State, the Honorable Theodore R. McKeldin, has honored us with his proclamation of "Doctors' Day," March 30, 1954.

The date of March 30th was not chosen at random, but is in commemoration of one of the greatest discoveries, for the alleviation of pain and suffering that our great country has yet produced. It was on this day, in 1842, when ETHER was first used as an anesthetic agent on a human being. Ether was not a new chemical at that time. It had no known use on the human body. It was known, however, that the inhalation of ether fumes would produce exhilarating effects. Inhalation was practiced for this effect at country parties, particularly in the South. Undoubtedly this was used in the same manner as alcohol in some individuals, also producing an exhilarating effect.

We have documentary evidence, that ether frolics frequently were held, the men present would inhale the fumes of the ether vapor and this practice sometimes formed the chief entertainment at these parties. These ether frolics probably suggested the use of this agent as an anesthetic, for during the frolics, the stage of excitement occasionally led to unconsciousness and loss of sensation.

Dr. Crawford Long of Georgia, having observed the loss of sensation incidental to injuries received during ether frolics, concluded that sulphuric ether might well be used to allay the pain of surgical operations. We must remember that prior to this time, there was no anesthetic available; operations that were done proved to be heroic affairs. The patient was drugged with opiates and stimulants, wheeled into the operating chamber where strong men helped to hold the patient in place, should the

restraints prove ineffectual. Many patients refused to undergo surgery even when a simple operation may have proven life-saving, purely because of the pain and suffering that occurred during the period of the surgery.

Therefore, on a date that we historically set as March 30th, 1842, Dr. Crawford Long administered ether to a young man, a Mr. James Venable and successfully removed two tumors from the man's neck.

The proclamation honors the entire medical profession, not only your family physician, whom you call in time of illness, but in addition the surgeon in the immaculate operating room who has been called into consultation by your family physician; the pathologist in his laboratory of the hospital, where the necessary tests of the blood and other materials of the body are performed; the research physician who devotes his life to the study of causes of disease; the public health physician who has made a long study of the relationship of various diseases and infections to the health of the general public and the methods to be used in the prevention of these illnesses; the radiologist who through the use of X-ray is able to explore and diagnose conditions in the deeper portions of the human body; the atomic physician with his Geiger counter, and study of the effect of radiation on experimental animals and unfortunately on some humans; the bacteriologist and the virologist who work with research physicians in the study of cause and effect.

We feel too, that this proclamation honors the fine citizens of our community who have given so much of their time to serve as members of the Board of Trustees of our modern, fine hospital; the administrator of the hospital and each and every one of the employees of the hospital.

We feel too, that this proclamation honors the Nursing Personnel who so kindly minister to us when we are ill; the physical therapist and the occupational therapist, who through physical

¹ Presented by Archie Robert Cohen, M.D., over radio station WARK, Hagerstown, Maryland, on the occasion of Doctors' Day, March 30, 1954.

² President, Washington County Medical Society.

means and mental occupation, aid in healing sick bodies and minds; the volunteers that work in the hospital to make the waiting hours so much more pleasant and less dreary; the secretaries to the physicians with their ability to keep a smile at the end of a trying day; and last but not the least, the wives of the physicians who are always on the job, serving meals to husbands at irregular hours, who are often disappointed as to pre-arranged plans when the phone call changes everything, always sending along the wire a note of cheer and advice until the doctor can reach your home.

Medicine has travelled a long way down the medical progress road in a fantastically short time. Today America is the healthiest large nation in the world. Babies born today can expect to live at least twenty years longer than those born in 1900. Women can face childbirth with little or no fear for the chances of surviving pregnancy. The dreaded diseases that were once killers—typhoid fever, small pox, diphtheria, pneumonia and many others—have been brought under control.

Since 1900 while our total population has more than doubled, the number of persons 65 years of age or older, has more than quadrupled. This accounts largely for the marked rise in death rates for heart disease, cancer and other diseases of old age.

Within a few decades, vitamins, sulfa drugs, antibiotics such as penicillin and the various mycin drugs, hormones, all have been added to the physicians armamentarium against disease. Surgeons today are performing delicate life saving operations on the heart, lungs, brain, stomach, kidneys and other vital organs which just a few short years ago would have been impossible.

Some critics point to the increasing death rate from heart disease and cancer as an indication of a medical crisis. Actually, this is a heartening sign of great medical progress. The median age at death in the United States has jumped from 30 to 66 years. Twenty years from now, although the death rate from certain diseases in our aging population may be higher, the length of life will be greater and the mortality rate for each age will be lower. Health progress and the number of deaths each successive year are simply two different ideas. A physician can never conquer death—he can only postpone it. Persons who are saved by medical advances and

skills from death at an early age, later fall victim to the degenerative diseases which now appear to be increasing.

A serious shortage of doctors has been alleged. Actually, we have more doctors than any other nation and we have more in proportion to population than any other country. For more than twenty years the supply of doctors has been increasing at a faster rate than the general population. It is estimated that the next ten years will bring another 30 per cent increase in the supply of physicians. Today we have a total of 220,104 physicians, the largest in our history. Of this number 159,120 are in active practice. All the rest, except 9,700 who have retired or given up the practice of medicine for various reasons, are serving American health needs in research, in teaching, in hospitals and in government service. On the basis of the estimated population approximately one physician is actually engaged in the practice of medicine for every 1,000 persons.

It is estimated that the efficiency of the average physician has increased about 30 per cent in the past fifteen years. This has come through the use of new drugs and antibiotics, new or improved techniques, modern equipment, increased auxiliary help from laboratories and technicians, improved transportation and communication and better coordination of all medical facilities.

Your doctor has spent a great many years in preparation for the day when he should be called to administer to an ill person. After his high school education has been completed, there are four years of pre-medical education and then four years of medical studies before he or she is ready to take the State Board of Medical Licensure examination. To be eligible for this examination the applicant must have graduated from an approved medical school of which there are approximately 80 in the United States, or from an approved foreign medical school. After successfully completing the examination, most of the physicians then spend several years in internship in a hospital that has been approved for intern training and at the present time, our hospital is approved for this training.

In addition to the above listed medical education already obtained by your doctor, he is constantly studying to further his medical knowledge and thus be enabled to treat you more efficiently, by use of newly discovered drugs and procedures. This study

consists of various meetings at the hospital, where your doctor spends about four hours each month in these meetings, in group discussions of the department in which he works or at general staff meetings.

At these general staff meetings, cases in the hospital, or recently discharged from the hospital, or deaths are thoroughly discussed; methods of diagnosis are reviewed; newer forms of treatment are described. All in all, these meetings serve as additional checks and balances as to the thorough care and treatment required for all cases admitted to the hospital.

Besides the hospital meetings—and your physician is required to attend 75 per cent of these meetings to maintain his membership on the staff—your doctor is a member of a number of other medical associations, which hold scientific meetings at least once a year, and often twice a year. A few of these are, the American Medical Association which meets for several days twice a year; the Medical and Chirurgical Faculty of the State of Maryland which holds two scientific sessions a year; the Washington County Medical Society, which has at least four scientific sessions a year. In addition to all this, your physician is a member of the Specialty group in which he limits his practice or of the American Academy of General Practice, if he is a general practitioner—

and most of the general practitioners in this county are members of the American Academy of General Practice. The latter group has a yearly convention of several days as well as frequent seminars for review and brushing up in the newer techniques.

The same holds true for the various specialty groups. A few of these by name are the American College of Surgeons, the American College of Physicians, the American Academy of Pediatrics, the American Board of Obstetricians and Gynecologists, the American Board of Ophthalmology and Otolaryngology, the American Board of Radiologists and other similar groups.

In view of the progress being made toward solving our health problems, we have reasons for encouragement but not complacency. The Washington County Medical Society has always accepted and carried out the responsibility of leadership in safeguarding the public health, raising the standards of medicine and making good medical care available to the people of our community.

We again thank our Governor for his thoughtfulness in proclaiming this day as "Doctors' Day" and to all of the people of our community, who have helped us so much in the observance of this day, we say, Many Thanks.

Clear Spring, Maryland

VOLUNTARY HEALTH INSURANCE—AN APPRAISAL AND A LOOK AHEAD^{1,2}

CARROL M. SHANKS

President, The Prudential Insurance Company of America

I am very appreciative of the opportunity to talk to you this afternoon—particularly so since you and the state medical societies you represent will be such potent factors in determining the future course of voluntary health insurance in America.

It is, of course, no new thing for doctors and insurance people to be discussing a common problem. Each day the profession and the industry make thousands of contacts one way or another. The imprint of the medical profession on insurance is a heavy one. You aid us in the selection of risks,

your work underlies our mortality and morbidity tables, and your assistance is essential to the disposition of many of our claims.

There are probably few places where the achievements of modern medicine are more clearly revealed than in the accumulated experience of insurance companies and in the mortality tables they employ. A review of the causes and frequency of death at the various ages made at twenty-five year intervals from seventy-five years ago to this day would at each quarter century date disclose notable advances. There come to mind readily the great reduction in infant mortality and in deaths during the childhood years. Discovery of specifics for such things as diabetes and pernicious anemia, the advances in chest surgery, the great extension of the field within which surgeons by reason of greater skill and better preoperative and postoperative care may operate, the lives saved by

¹ Presented before Conference of Presidents and Other Officers of State Medical Association, New York City, May 31, 1953.

² Reprinted by the courtesy of Mr. Carrol M. Shanks and Missouri Medicine (Pages 118-121, February 1954).

the sulfonamides and penicillin and the effective use of blood and blood plasma—these are but random samples and could be easily multiplied. In looking ahead we see the broad attack now being directed against the degenerative diseases which by reason of the earlier advances now loom so formidable. In connection with this matter of degenerative diseases, I am glad to be able to tell you that the life insurance industry for the last eight years has been actively promoting research having to do with the disease of the heart and arteries. More than five and a half million dollars have been contributed thus far. Two hundred and five separate programs have been supported and 241 research fellowships established.

This story of medical advances is an old story to you but almost necessarily rises afresh in the mind of an insurance man seriously considering the relations between medicine and insurance. Of course the practice of medicine and the effective distribution of medical care are both open to constant improvement, as just one good backward look will indicate. The road in each case stretches endlessly ahead, but the record already written is outstanding and entitles the physician to the gratitude of the nation. All over the world the quest for better health and the effort to prevent needless loss of life proceeds. A glimpse of this general scene only serves to emphasize how fortunate we are as a people in the kind and quality of health care already available to us.

It so happens these major medical advances have been made without the aid of prepaid care as we know it. This being so, it is easy to understand the occasional irritation of doctors caused by the use of the words "health insurance" in a fashion indicating that health insurance is the equivalent of health care itself. In other words, the inference is raised that so many dollars of health insurance will automatically buy so much improved medical care. Voluntary health insurance can ease the financial burdens of individuals and families, and its existence in many instances will result in the obtaining of better medical care. But the words are not interchangeable and primarily the improvement in care must come from the physician.

Now I should like to make with you a brief appraisal of voluntary health insurance as it stands today. What has been accomplished thus far? And is this movement deserving of our continued interest?

One major test is the number of people covered. The last complete figures I have dealing with medical, surgical and hospital expense insurance—the areas covered by insurance companies and Blue Cross and Blue Shield—are Health Insurance Council figures as of December 31, 1951. At that time it was estimated that 85 million people were covered for some form of hospitalization insurance; about 41 million by Blue Cross and Medical Society plans, and about 45 million by insurance companies. For surgical expense insurance covered about 65 million persons; about 24 million by Blue Cross and Medical Society plans, and about 41 million by insurance company plans. And for medical expense insurance about 26 million people; 14 million by Blue Cross and Medical Society plans and about 12 million by insurance companies. Duplication of coverage prevents the presentation of precise figures as to individuals covered, but the figures are about as indicated. Tentative projections carrying these

figures to the end of 1952 indicate that the total coverage at the time probably amounted, in the case of hospitalization, to 90 million covered; in the case of surgical expense insurance to 72 million covered, and in the case of medical expense insurance to 32 million covered.

These figures standing alone constitute a noteworthy achievement. Actually, however, these figures deal only with the coverages in the areas in which the insurance companies and Blue Cross and Blue Shield all are active. There is outside this area and provided either by insurance companies alone or other private plans substantial protection which directly or indirectly supplies a considerable sum of money to meet health care expenses.

As long ago as December 31, 1951, there existed independent private plans such as industrial, community or consumer plans, or private group clinics or university health plans which provided hospital care for three and a half million people and provided surgical and medical care for 2,700,000 people. These figures today are undoubtedly larger.

The insurance companies provided loss of income benefits for varying periods for 31 million wage earners at the end of 1951 and approximately one third as many persons were covered through paid sick leave in private industry or in civilian government service, union administered plans and employee mutual benefit associations. These funds which meet the basic need of replacing a portion of the wage earner's income during sickness make possible the payment of doctor bills and hospital bills that otherwise would not be paid as promptly or, in many instances, at all.

There are, in addition, considerable sums paid under workmen's compensation policies, under total permanent disability benefit provisions in life insurance policies, under commercial accident policies issued to 4,800,000 persons, under group accidental death and dismemberment insurance issued to about nine and a half million people, and under commercial accident policies covering specified risks in the case of eight million people.

And then there are the very large sums approximating several billion dollars yearly paid out under life insurance policies. Little of this money goes direct from insurance companies into the hands of doctors as it is primarily utilized for general family living expenses and to achieve family aims. However, general family living expenses and general family aims these days include sizeable payments for hospital and medical care charges. Thus, life insurance in an unknown but very appreciable amount also enters the picture.

From this recital it can be seen that there is a very considerable amount of insurance protection which, although it is not always thought of as so doing, buttresses the voluntary health insurance program.

In considering the proportion of the population covered, it is also to be remembered that there are people, probably relatively small in number, who have no need of insurance protection. There are also a very considerable number of persons such as service men and other beneficiaries of governmental programs for whom adequate medical and hospital care is already available should they choose to accept it. So this field that we must cover is not as large as it is sometimes stated to be.

Thus rather an amazing start has been made in enlisting public participation in the voluntary health insurance program. This view is strengthened by consideration of the fact that hospitalization and surgical expense insurance in volume, as we now think of it, had its biggest growth commencing in the '40s and that medical expense insurance has had its greatest growth since the last World War. How many voluntary conceptions have progressed as rapidly?

The plans themselves are much more adequate. It is true that many plans do not satisfactorily meet present day medical and hospital costs. It is also true, however, that in connection with a large share of the business, upward revisions of the plan have already been effected and that this process continually goes on and that the level of benefits on the whole has steadily risen. Furthermore, the inflationary problem of recent years had made the job of catching up much more difficult. Moreover, it should be remembered that when some of these plans are written, the choice facing the insurance companies is not between writing an adequate or inadequate plan, but between writing a less than adequate plan or none at all. Under these circumstances it seems best that some start be made by developing some immediate protection. Many of these plans are later increased. Employers and individuals, moreover, on occasion have just so much to spend, and they insist on splitting the money thus available between medical, surgical and hospital protection on the one hand, and protection in the field of life insurance or loss of income or for some family purpose unrelated to insurance.

We have been dealing with the number of persons covered and the level of benefits. Voluntary health insurance by reason of the experience of the years has been the gainer in other fields.

We are possessed of a knowledge and resourcefulness we did not have when we started. When we started in, we had but few trained men. Today, though the supply of trained people is still inadequate, all the voluntary plans do have many people—actuaries, salesmen, clerical staffs, administrators, executives, claim people—substantially trained to meet the problems of the future.

Then we have preserved our freedom of action and our right to experiment. No monopoly has developed, and each major insuring agency has acted as a stimulus to the other agencies to provide more attractive plans and improved service for the public. Blue Cross and Blue Shield plans and insurance company plans are all probably better than they would have been had these agencies not acted as a spur to one another. Some of the other private plans will undoubtedly act as a stimulus to these three groups in turn.

In earlier days we were selling to a public largely unacquainted with the benefits voluntary health insurance could provide. Today we have a public which is much more aware of the value of our products and one which has had the benefit of a practical demonstration of that value by the payment of millions of claims.

We have now reached the point where I should like to look ahead with you and consider some of the problems of the future, and give thought as to how we can make voluntary health insurance still a more effective social instrument for good.

The problem has so many aspects—political, social, insurance, medical, etc.—that I could not begin to cover them all. I will therefore discuss with you a few general matters and some problems and matters of particular concern to insurance companies and doctors.

In the problem field we must continue to vigorously press and expand the sale of voluntary health insurance. My company, which has been issuing the group coverages for years, entered the individual and family hospital and surgical and income fields a little less than two years ago, largely because of the feeling that we must all do our part. Numbers of other insurance companies have entered the field as well.

Moreover, we must not only do more in the fields which have hitherto received principal attention at our hands but will now be obliged to direct a large share of our work to the more difficult areas. We shall have to deal more effectively with the problems of the older persons, the persons not presently reached by insurance companies through their group plans or by Blue Cross or Blue Shield. We shall have to deal with the retired person and with the problem of chronic illness and major medical expense. The problem of increasing diagnostic service will probably loom larger. Just how far the insurance principles can be utilized in all these fields remains to be seen. Encouraging starts have, however, been made in a number of these areas as in the case of older persons and retired persons, and the ingenuity and experience we have gained will do much to aid in the solution of these problems.

Substandard risks are satisfactorily cared for by group insurance. Here there is no need for evidence of insurability, but a substandard case in individual accident and health insurance is more difficult. Here again we must seek to move forward.

One of the basic needs, and probably the one on which the success of voluntary health insurance depends more than any other, is that there be effective cooperation in the public interest between the insuring agencies and the medical profession and the hospitals who furnish the necessary services. I do not believe the importance of this factor can be overestimated. There are many reasons why this is so. We are, for instance, moving into an era of prepaid care. This will obviously produce a greater utilization of facilities than is the case in a population without such insurance. Some of this increased utilization will be good, namely, that which results in necessary care being provided where it would not have been provided without the existence of prepaid coverage. On the other hand, possession of such coverage will undoubtedly produce in certain cases an over-utilization of its facilities merely because the coverage is present. Those who write the insurance and those who provide the service will both have an interest in facilitating the increased utilization in the one case and restraining it in the other. Such restraint as occurs will not have as its object primarily the saving of money but the preservation of the basic plans for those who need them. These could easily be destroyed and priced out of the market.

We need deeper recognition of our joint obligation to the public. In other words, it is not enough that we just properly handle our own end of each situation. A man in a hospital, for instance, under doctor's orders is not three different per-

sons with three separate problems, but one man with one three-sided problem. Soliciting the support of the public and proclaiming the superiority of voluntary insurance, as we do, we can do no less than cooperate together to see that our joint handling of his case shall be made as easy and as convenient and as understanding as possible. The patient is a whole man, and he is justified in demanding that he be treated as such. And we will be wise to heed that demand.

One of the prime problems confronting us is, of course, that we furnish the full and more adequate benefits demanded by the public at reasonable cost. The physician must and should be adequately compensated for his work, and our plans must be kept financially sound—not only for ourselves but for the participants in the plan. But we must still see that the job is done at a cost which the patient may reasonably be expected to pay. Should we fail to meet the reasonable expectation of the public in this regard, the solution will not be abandonment of public demand for adequate coverage but a turn to some governmental operation.

The need for what I have been talking about is readily seen in the problems involved in furnishing protection against major or catastrophic medical and hospital expense. Today companies are actually pushing the sale of coverages providing for losses up to two or five or ten thousand dollars. This is an area in which there have been repeated cries for assistance. Now we are trying to do something about it, but there can be no hope of successfully doing so unless costs and charges are kept at their true level. One part of the problem we try to solve by making the insured a co-insurer which makes him a part payer of the bill. The other principal safeguard must be the sympathetic understanding of the insurance principles involved on the part of those who furnish the service and their personal integrity in giving that understanding practical effect.

Should insurance fees merely be utilized to increase the cost of insurance, the whole purpose of taking out the insurance is defeated and sooner or later the scheme must fall to the ground. The doctors of course have been confronted with the same inflationary problem as all the rest of us, and, as I have said, any system must see that they are properly compensated for their work. But, as I have also said, if insurance which was taken out with the specific purpose of meeting all or a certain portion of a medical bill is converted into the basis for increasing that bill, the desire to plan for and anticipate medical costs is greatly lessened, if not destroyed.

A great deal of educational work has been done. Insurance people better understand medical procedures and practices, and doctors better comprehend some of the basic insurance principles. But a much more thorough job needs to be done in this respect, and the matter must be gotten home to more insurance people and to many more doctors. A voluntary insurance system moves only through the direct efforts of the people who believe in it. There is no outside directing force, nor any feat of legerdemain that will do this job for us. If we are to move in this field, it means that literally thousands of insurance people and the doctors at the local level will have to have a better understanding of the principles involved in the successful operation of voluntary insurance

and will have to see the need for proper support of things that are in the public's interest.

While I shall not dwell on it, just the mechanical work necessarily involved in the payment of claims makes it desirable that we establish systems that are easy and as effective as possible.

Generally speaking, I have found medical men keenly interested in the spread of voluntary insurance and anxious to encourage all able and honest agencies working in the field. I must confess, however, that I am somewhat surprised to occasionally find doctors and societies who do not see the need for according substantial equality of treatment in the matter of charges to policyholders of insurance companies and participants under Blue Cross and Blue Shield plans.

I have no doubt of the sincerity of the views of most such men and of their understandable attachment to a program which has been so very beneficial and which they may have originated or of which in any event they play an active part. Nor is any criticism intended of the great service performed by them.

However, I should like to advance for your consideration the suggestion that the view thus taken fails to take full account of the obligation to the purchasers of voluntary insurance or of the true interests of the medical profession itself.

The medical profession has sought and sought successfully thus far to maintain its independence and to maintain a system preserving the right of the patient to a free choice of a physician and to avoid having its fees set for it by government. The stronger and broader the existing voluntary insurance system the better position the medical profession will be in to maintain these principles.

Is the freedom thus accorded to the medical profession to be utilized to deny to others a free unregimented choice as to how they should choose to meet their medical costs?

The profession pled for public support in its fight against compulsory health insurance. It sought the support of its patients and the general public. It sought to encourage the spread of voluntary insurance in every possible sound manner. Does it now wish, after having obtained such support, to deny equality of treatment in the matters of fees to anyone who obtains his protection other than through certain specified agencies however beneficial they may be? In other words, is voluntary insurance to be voluntary or only theoretically so?

It has been the pride of the profession through the years that all people in the same financial circumstances and in the same degree of physical and mental distress shall receive the same treatment—medical treatment and financial treatment. Is that a standard from which it is wise to wander?

Just a few additional brief words. We now have an administration in Washington inclined to look more favorably on private attempts to solve the problem of medical care costs. We will be wise, all of us, to work on this problem now. We will be wise, furthermore, to recognize that this means you and it means me. If we have too many other things to do, or if the organization we represent can spare no time for this, then we can hardly be heard to complain when other means

are sought to accomplish these aims. All the good will in the world will not have the value of a sound bit of constructive work.

We have come a long way with voluntary health insurance. Many problems and much work lies ahead, but I am sure that we can all take heart from what has been accomplished thus far. Above all, let us keep our thinking broad and our sights high. Let us remember that we all exist—doctors, hospitals and insurance agencies—simply as a mechanism

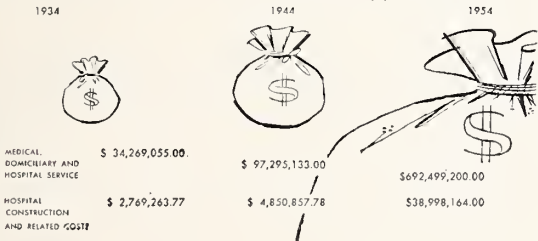
through which the public can best achieve its purposes, namely, better health care and a better and more satisfactory method of financing the cost of that care. If we keep our minds on these essential purposes, cooperating where we properly may to achieve them better, we will not be needlessly diverted or divided by unimportant and lesser matters, and we shall the sooner realize our goal.

*The Prudential Insurance Company of America
Newark 1, New Jersey*

In Viewing the VA Medical Program . . .

increasing tax burden

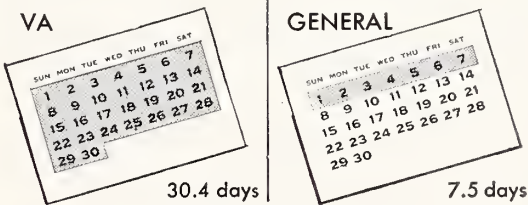
VA Medical Appropriations



In twenty years, the cost of the VA medical program to U. S. taxpayers has increased 1,875%. Yet only 15% of the patients treated in VA hospitals are veterans with disabilities incurred while in uniform. The VA medical program is now second in size and expense only to the nation-wide system of socialized medicine in Great Britain.

In Viewing the VA Medical Program . . .

comparison of length of stay
in VA and general hospitals
GM&S



General medical and surgical patients in VA hospitals are confined four times longer than in non-federal hospitals. VA hospitals admit patients for examination, diagnosis, and treatment, much of which is normally undertaken outside civilian hospitals. Also, VA patients often remain hospitalized throughout the entire medical treatment period, whereas non-VA patients are usually treated at home during their convalescence. This is a major factor in the tremendous cost of the VA medical program.

Component Medical Societies

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

It is well into the month of May as this material for the July number is assembling. The various problems having to do with the end of a school year and beginning summer take everyone's attention. The Executive Board and the Executive Committee continue to meet regularly, and handle the problems brought before them with care and dispatch.

The American Medical Association sent a communication requesting appointment of a committee to study the problem of alcohol. This was considered and referred to State level for further action. It had nothing to do with the recent symposium on alcoholism held by the Committee on Medical-Legal Problems with C. Holmes Boyd, M.D. as moderator earlier in May.

A proposed "preventive program in chronic diseases" (BOASI Program) for employees of the Bureau of Old-Age and Survivors Insurance, Department of Health, Education, and Welfare was presented by Dr. William T. Doran, Jr., Medical Director of the Department. This program has been "approved" only by the Medical Board in Birmingham, Alabama where the pilot study was made. He described how the BOASI 'aid station' will do screening, similar to that done by the Commission on Chronic Illness. The Government allocates a fixed \$8.00 per employee per year, which permits screening and referral to practicing physicians and clinics. Discussion was vigorous. President Gundry was directed to canvass the Medical Board and in accordance with information obtained, act on his own best judgment.*

State licensure for Laboratory Technicians has been discussed. Laboratory-interested physicians were heard at one sitting, and also those who favor such a law. The Society feels that it has merit in supervising and control of Laboratories, but was

* As the JOURNAL goes to press, I understand this was approved.

opposed to the proposal which was directed toward licensing of Laboratory Technicians.

BALTIMORE COUNTY MEDICAL ASSOCIATION

SAMUEL P. SCALIA, M.D.

Journal Representative

The Dundalk YMCA was the scene of the May luncheon meeting of the Baltimore County Medical Association.

This meeting was held May 19, 1954. The following physicians were voted membership in the society: Dr. Robert E. Thomas, active member; Dr. Kevin Quinn, active member; Dr. Louis J. Kolodner, associate member.

It was announced by the Journal Representative that the November issue of the State JOURNAL is to be dedicated to Baltimore County. Any county physician having any material that he believes worthy of publication should contact Dr. Scalia.

Dr. O'Donnell presented to the members a resolution *opposing* the licensing of medical or laboratory technicians. This licensing procedure would make it illegal for a nurse or a secretary to do any routine laboratory work after a physician trained her. The resolution was unanimously adopted.

Dr. O'Donnell also began an active discussion on the state Health Department Laboratories. Too many physicians use the laboratories for all sorts of laboratory procedures and yet charge the patient full fee. The consensus of opinion seemed to be that the State laboratories should be used only for communicable diseases or for indigent and Medical Care patients. It was decided that Mr. Wells, our Legal Counsel, should draw up a resolution for the next meeting.

Dr. Melvin Davis next presented a resolution regarding Medical Care in the State of Maryland. The Medical and Chirurgical Faculty is to review the pro-rata and the pro-capita plans as they now exist and decide once and for all which plan to

adopt for the entire State. A motion was made and carried, concerning this very important affair.

The scientific portion of the meeting was handled by Dr. Roy Scholz. His subject was "The Treatment of Diseases of the Eye in General Practice." His talk was illustrated by colored slides and a moving picture. Dr. Scholz gave a very interesting and instructive presentation.

CARROLL COUNTY MEDICAL SOCIETY

WILLIAM L. STEWART, M.D.

Journal Representative

A regular meeting of the Carroll County Medical Society was held at the Hoffman Inn, Westminster, on May 19, 1954 with 23 members present.

A motion was made and passed that annual dues for the Carroll County Medical Society be increased from their present rate of \$7.00 to \$15.00 to meet current operating expenses.

The matter of state licensure of medical technologists was brought up and after a round table discussion it was decided unanimously that the Society should go on record as disapproving this proposed law.

Our guest speaker was Dr. C. W. Stewart of Baltimore. He gave us a very interesting talk on the deficiency anemias.

All members of the Society wish to express their distress over Dr. Woodward's recent illness and we all join in best wishes for a speedy recovery.

HARFORD COUNTY MEDICAL SOCIETY

FREDERICK J. HATEM, M.D.

Journal Representative

Minutes of meeting, April 29, 1954.

Members present: Brendle, Finney, Hatem, Ho-

dous, Marek, Norment, Rodman, Stewart. Guest: Fisher.

The meeting was held at the Colonial Hotel, in conjunction with cocktails and dinner. In the absence of the president and vice-president, the secretary presided. Dr. William S. Love spoke on the purposes and activities of the Heart Association and asked the Society to reconsider endorsing a local chapter of the Heart Association.

Old Business: 1. Dr. Edward C. Loo of Havre de Grace elected to regular membership.

New Business: 1. Coverage of farmers' employees under the Workmen's Compensation Laws. It was decided that a letter be written to the Committee on Industrial Health of the state society asking that a study be made to determine if there is a possibility of changing to Workmen's Compensation law so that farmers' employees be included.

2. Mass tetanus immunization of farmers. It was decided to write the County Health Department inquiring into the possibilities.

3. Heart Association. After much discussion and misunderstanding, it was voted that the Society endorse a local chapter of the Heart Association.

KENT COUNTY MEDICAL SOCIETY

O. S. GULBRANDSEN, M.D.

Journal Representative

The Quarterly meeting of the Upper Eastern Shore Medical Society was held at the Chester River Yacht and Country Club, Chestertown, on April 22, 1954. Representatives of Caroline, Kent, Queen Anne's and Talbot County Medical Societies attended.

Dr. George H. Yeager, former Secretary of the State Society and Professor of Medicine at the University of Maryland, spoke on "Peripheral Vascular Disease," and a movie, "Intra-Articular Injection of Hydrocortisone," was shown.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

TUBERCULOSIS

LOUIS KRAUSE, M.D.*

This disease certainly must have existed from the earliest days of human history, even perhaps in the animals also. While it is difficult to trace the disease etiologically to the great past, certainly our anatomical remains and the descriptive literature throughout the ages indicate that it was probably quite widespread. The osteological findings in the mummies of Egypt certainly suggest its extensive occurrence at that time.

Among the skeletal remains studied by Sir Marc Armand Ruffer, there were found skeletons with a very characteristic hunchback, collapsed vertebra, huge abscessed cavities with remains of sinus tract scars in the psoas muscle. Here we have undoubted evidence of ancient Pott's Disease, on a tuberculosis basis in all likelihood. Since the turn of our century, for many reasons, a decline in the incidence of disease occurred, but of course, nothing so dramatic as we have in our own present era with the chemotherapy control. For the exciting story of this and the depressing story of the "white plague" in days gone by, see the following list of books, plus recent periodical articles also in the library:

TUBERCULOSIS

(A list of books selected from several hundred on the subject in the Faculty Library)

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- Baillie, M. The morbid anatomy of some of the most important parts of the human body. 1st. Am. ed. Albany, Barber and Southwick, 1795.
- Bayle, G. L. Recherches sur la phthisie pulmonaire. Paris, Gabon, 1810.
- Bodington, G. An essay on the treatment and cure of pulmonary consumption. Reprinted. London, Simpkin, Marshall, 1906.

* Chairman, Library Committee.

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- Both, C. Consumption and its treatment in all its forms. Boston, A. Moore, 1873.
- Brown, L. The story of clinical pulmonary tuberculosis. Baltimore, Williams & Wilkins, 1941.
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- Davies, H. M. Surgery of the lung and pleura. London, N. Y., H. Milford, Oxford Univ. Press, 1930.
- Dumarest, F. La pratique du pneumothorax thérapeutique. 4th. ed., Paris Masson & Cie, 1936.
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- management and prevention. London, Oxford, 1939.
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- Louis, P. C. A. Researches on phthisis, anatomical, pathological and therapeutical. 2d. ed. London, Printed for the Sydenham society, 1844.
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LIBRARY CHATTER

We hope all Faculty members are sure that they are always welcome in the Library, but we'd like to issue a special invitation to visit us during the summer months. No parking worries, just park in the back of the building, come in and look over the books at your leisure. Our new open shelves hold all those added in the past ten years and they are easily accessible. No more sending back to the stacks for each title! The office and journal room are air-conditioned and, as some members found out last summer, are very pleasant and comfortable places in which to study or just pass time catching up on your reading. The latest issues of over three hundred medical journals are always available.

Of course, if you insist on reading at home in shorts with something long and cool at your elbow, you

may borrow what you like to take along. The following suggestions are offered as good hot-weather reading fare:

Browne, *The scalpel of Scotland Yard*

"Presenting the life story of a famous pathologist, here is a book filled with fascinating and absorbing details of some of the greatest of modern murder trials. Second to none in the field of forensic medicine, Sir Bernard Spilsbury was called 'the incomparable witness.' His name became legendary in the annals of Scotland Yard, his practices were accepted by police the world over."

Bett, *The infirmities of genius*

"Does genius depend upon some external stimulus, such as alcohol or drugs, or some abnormality of character, to produce its most brilliant results? Dr. Bett discusses this question in a penetrating survey of the lives of fifteen famous literary figures."

Hirst, *The conquest of plague*

"This book begins with a brief account of traditional beliefs about the cause of pestilence, then traces the main sources of human infection and ends by showing how recent advances in knowledge have led to the conquest of plague, the most ancient and most deadly of epidemic diseases."

Bond, Thomas W. Salmon, *psychiatrist*

"Here, related with warmth and intimate understanding, is the life story of a renowned and beloved psychiatrist, the leading American pioneer in the field of mental hygiene. Throughout this record of his outward achievements glows the personality of a remarkable man."

Pickard and Buley, *The Midwest pioneer, his ills, cures, & doctors*

Dedicated "To the pioneer doctor who boldly faced the wilderness; and to the pioneer who bravely faced the doctor," the authors present a non-technical account of medicine in the early Middle West which adds an important chapter to the always-fascinating history of the region and period.

Oberndorf, ed., *The psychiatric novels of Oliver Wendell Holmes*

"Dr. Oberndorf has drawn upon his rich clinical experience to supplement and interpret Holmes' descriptions of psychopathic conditions. The book is a novel idea in psychiatric presentation and will appeal to everyone who is interested in the social aspect of mental disease."

Leonardo, *History of medical thought, an essay*

"The author has attempted to show the influence of philosophy on medicine throughout the ages, and its responsibility for prevailing medical and surgical concepts."

Hume, *Doctors East, doctors West*

"This book is the personal record of how one American doctor discovered that medicine was a builder of bridges between nations and cultures."

Powell, *Bring out your dead*

The outbreak of yellow fever in Philadelphia in 1793 was one of the great tragic episodes in American history. The author brings out the human values of those hundred days of horror, "with all the cowardice and courage, the cynicism and faith, the knowledge and the vanity that people have."

M. E. B.

INFECTIOUS HEPATITIS INCIDENCE DOUBLE 1953

The AMA Washington Letter, 66

Office of Vital Statistics data show that the number of reported cases of infectious hepatitis in the first quarter of this year was more than double the total for the comparative period last year. The respective totals are 17,120 and 8,216. For the same months in 1952 the total was 6,289. In announcing the figures, the office states: "Some of the increase is undoubtedly due to better reporting, but epidemiological information on outbreaks indicates that there may be a real increase in the incidence. Many outbreaks have occurred among school populations, and with the closing of schools this summer, the incidence may be expected to decrease as in the previous two years, reaching a low for the year sometime in July or August. As in 1952 and 1953, the incidence this year may begin to decline early, and by June may be well below the peak."

Health Departments

MARYLAND STATE DEPARTMENT OF HEALTH

Gamma Globulin Distribution, 1954

May 10, 1954

Dr. George H. Yeager, Editor
Maryland State Medical Journal
1211 Cathedral Street
Baltimore 1, Maryland

Dear Dr. Yeager:

I am enclosing material describing gamma globulin distribution in 1954. This is of current interest to many physicians and the State Board of Health expressed the hope that it would be printed in an early issue of the *Journal*.

At its meeting on April 14, 1954, discussion by the Board centered on the dilemma of distributing gamma globulin for use in connection with poliomyelitis in the face of insufficient evidence of its effectiveness. Indeed, the evidence accumulated from the evaluation studies carried out in 1953 casts considerable doubt on the effectiveness of gamma globulin.

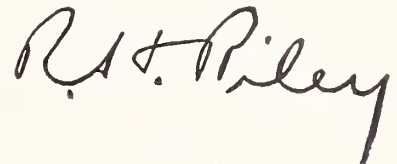
The summary of the report of the National Advisory Committee for Evaluation of gamma globulin in prophylaxis of paralytic poliomyelitis—1953, as printed in the *Journal of The American Medical Association*, March 27, 1954, p. 1086, comments: "Its value in community prophylaxis as practiced during 1953 has not been demonstrated. . . ." and again "No valid basis was found for drawing confident conclusions as to its preventive effect. . . . The administration of gamma globulin to familial associates of patients with poliomyelitis has had no significant influence on (1) the severity of paralysis developing in subsequent cases; (2) the proportion of non-paralytic poliomyelitis occurring in subsequent cases in which G. G. was given before the onset; and (3) the classic pattern of familial aggregation of cases in the country at large."

With the above information in mind, the Board considered several possible methods of distribution of gamma globulin for use in connection with poliomyelitis. The recommendations of this Department are

contained in the attached circular Gamma Globulin Letter No. 1 dated April 14, 1954.

I will appreciate it if this material can be incorporated in the next issue of the *Journal*.

Very sincerely yours,



Director

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St.

Baltimore 18, Maryland

April 14, 1954

GAMMA GLOBULIN DISTRIBUTION—1954

Gamma Globulin Letter No. 1

To: County Health Officers

Subject: Use and Distribution of Gamma Globulin

MEASLES: Gamma globulin (immune globulin human) has been definitely proved to be of great value in the control of measles.

Indications for use:

- A. Complete prevention by passive immunization with immune globulin human *should* be attempted as follows:
 1. Contacts less than three years of age
 2. Contacts among children ill with other diseases (particularly tuberculosis and rheumatic fever).
 3. Contacts among children in hospitals or institutions
- B. Partial prevention *may* be attempted at the discretion of the family physician by inducing an attack of modified measles as follows:
 1. Contacts among all other children between three years and 16 years of age.

Dosage:

For prevention: 0.1 cc per pound of body weight (intramuscularly) as soon as possible after exposure. Dose increases if more than six days after exposure.

For modification: 0.02 cc per pound of body weight (intramuscularly).

INFECTIOUS HEPATITIS: Gamma globulin (immune globulin human) has been definitely proved to be of great value in the control of infectious hepatitis. Where GG has been used to control an outbreak of infectious hepatitis, the rate for the inoculated has been reduced to

10% as compared with those uninoculated, and even though used in younger age groups only, it has reduced the rate for all ages and for the entire community. The use of GG is therefore approved to control hepatitis outbreaks in groups such as schools and children's institutions as well as among household contacts. Indications for the former will be determined by the local health officer in consultation with the State Health Department.

Indications for use:

1. Household contacts of clinically diagnosed cases.
2. Schools, children's homes, or other institutions where the size and nature of the outbreak is such that the local health officer in consultation with the State Health Department approves its use.

Dosage: 0.02 cc per pound of body weight (intramuscularly) within first week after exposure.

POLIOMYELITIS: Action taken by the State Board of Health—April 14, 1954—The Maryland State Board of Health at its meeting on April 14, 1954, studied the "Summary Report of the National Advisory Committee for the Evaluation of Gamma Globulin in the Prophylaxis of Poliomyelitis in 1953" as published in the Journal of the American Medical Association of March 27, 1954. It was the considered opinion of the Board that no present evidence existed from the 1953 tests, as set forth in the "Summary Report", that Gamma Globulin is of value in the prevention or modification of poliomyelitis.

Nevertheless, since there is at present some division of opinion on this matter, and since Gamma Globulin will be available in 1954, the Maryland State Department of Health will supply Gamma Globulin to practicing physicians on their request after consultation with the local health officer, if, in the judgment of the physician, he wishes to use it.

Indications for use: Lack of evidence prevents establishment of valid criteria for use.

Dosage: Unknown. A "somewhat higher amount" than the 0.14 cc per pound used in 1953 has been suggested. Gamma Globulin Letter No. 28—April 7, 1954, states "In 1953 the average dose was 7 cc; it is recommended that this be increased to 10 cc in 1954."

GERMAN MEASLES: (Rubella)

Indications for use: If exposure occurs, immunization with immune globulin human should be attempted in pregnant women who have not had German measles and who are in the first five months of pregnancy.

Dosage: 0.1 cc per pound of body weight (intramuscularly) should be given as soon as possible after exposure.

HYPOGAMMAGLOBULINEMIA: This is a rare clinical entity recently described. It is characterized by a deficient ability to form antibodies. In this condition the regular repeated administration of gamma globulin is required to maintain the resistance of the patient to infection and may be life saving. Inquiry regarding its use for this condition should be made directly to the State Health Department.

DISTRIBUTION

Working supplies of gamma globulin will be placed in each local health department. *Only licensed physicians may request gamma globulin.* In order to obtain G.G. for prophylaxis of any of the above conditions, physicians are required to furnish to the local health department information on the name, date of onset, and diagnosis of the patient as well as the names and ages of contacts to be inoculated, and the amount of gamma globulin to be used.

An exception to this would be made in the case of schools, camps, or other group situations when the local health department arranges for the inoculations to be given. In this instance the local health department would prepare a *summary* of the number and ages of children inoculated, the disease involved, and the total amount of gamma globulin used. Physician's request forms—(CD-3) will be supplied for this purpose. The same form will also be used by the local health department to prepare a summary in the case of group inoculations. *In order to obtain replacement of the gamma globulin issued, the local health department must submit a copy of the request form (CD-3) together with a duplicate requisition.*

PACKAGING AND LABELING

A. Packaging

Gamma globulin solution for prophylaxis of measles, infectious hepatitis, and for other special purposes will be provided primarily in 2 cc vials. However, there will be some available also in 10 cc vials. It will therefore be necessary to keep these supplies separate from that reserved for poliomyelitis which will be provided only in 10 cc vials.

B. Labeling

Most of the material available for 1954 will be labeled "Poliomyelitis Immune Globulin (Human)".

Occasional lots of material will be labeled "Immune Serum Globulin (Human)".

Such material is intended in all instances for uses *other* than for poliomyelitis.

The material labeled "Poliomyelitis Immune Globulin Human" is intended for prophylaxis of measles, infectious hepatitis and for other special purposes as well as for poliomyelitis. The State Health Department regrets the confusion in labeling. It will be necessary for each local health department to keep separate the material issued for use in measles, infectious hepatitis and other special purposes from that issued for poliomyelitis.

BALTIMORE CITY HEALTH DEPARTMENT

Tuberculosis Mortality Declines Sharply No Change Seen In Morbidity

A review of the mortality record of Baltimore residents during the first four months of 1954

indicates that the striking decline of tuberculosis deaths noted in 1953 is continuing into the current year. There were 61 tuberculosis deaths from January 1 through April 30, 1954, compared to 108 during the same period of 1953, a drop of 43 per cent. The decline in tuberculosis in the white population was approximately 50 per cent, and it was 33 per cent in the colored population. Should this trend continue, and there is little reason to believe otherwise, annual tuberculosis mortality rates for 1954 will drop to 10 per 100,000 population for the white segment and 35 per 100,000 for the Negro population.

Barring some unforeseen conditions affecting the nutritional status of the population, it is not unreasonable to forecast that tuberculosis within the coming decade will take its place with many of the other communicable diseases as a relatively insignificant cause of mortality.

However, much remains to be done before the disease can be considered effectively controlled. In spite of the tremendous advance in the prevention of deaths from tuberculosis, the annual occurrence of new cases involving serious illness and disability shows no clear evidence of decline.

Consistently within the last five years, from 1,350 to 1,500 cases of tuberculosis have been reported each year. This would seem to indicate that there has been no recognizable drop in the number of persons in this city who are attacked by this disease, but rather that more effective methods of treatment have reduced the likelihood of death from tuberculosis.

Since the incidence of tuberculosis continues at a

relatively high rate, no diminution is expected at present in the need for a tuberculosis hospital service of sufficient capacity to provide beds promptly for the many cases requiring inpatient care. The rapidity with which the progress of disease can now be arrested will no doubt result in shortened lengths of stay. This will increase the need for follow-up care and supervision in the home, a service rendered largely by the public health nurses cooperating with the Bureau of Tuberculosis. Additional investment of time by the public health nursing service in tuberculosis care was necessary in 1953 as a result of an extensive home treatment program in which streptomycin in combination with other drugs was administered under the direction of the Bureau of Tuberculosis.

Reduction in the reservoir of disease in the community is the logical objective for further control effort. Rendering the known cases of tuberculosis bacteriologically negative as rapidly as possible, and finding the unknown case before it can serve as a focus of infection for other contacts, form the rational steps which should guide the practitioner and the health department in a joint effort to reduce the incidence of tuberculosis to a minimum. Elimination of tuberculosis as a public health problem may now be within the realm of possibility. However, there will long remain the task of the rehabilitation of former tuberculous patients.

Huntington Williams, M.D.

Commissioner of Health

MD'S NEVER STOP STUDYING

A. M. A. News Notes, Vol. 3, No. 2

In these busy times the average practicing physician still manages to devote the equivalent of 83.3 eight-hour days a year to keeping abreast of current developments in the field of medicine. This striking figure is one of many brought out in a preliminary report by the AMA'S Council on Medical Education and Hospitals on its recent survey of postgraduate medical education. Survey findings are based on data compiled on personal visits to more than 220 institutions engaged in postgraduate medical education as well as 5,000 questionnaires received from a random sample of 17,000 practicing physicians throughout the country.

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT
Case Reports Received during 4-week Period, May 28-June 24, 1954

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County.....	35	1	7	1	159	—	81	—	—	—	19	1	—	5	5	—	6	e-1	2
Anne Arundel.....	6	—	—	7	55	—	9	—	—	—	1	—	—	—	11	—	3	ty-1	2
Howard.....	1	—	2	3	6	—	2	—	—	—	1	—	—	1	1	—	1	p-1	—
Harford.....	4	—	4	7	87	—	6	—	—	2	4	—	—	—	—	—	—	—	1
Carroll.....	—	—	—	—	1	—	—	—	—	—	2	—	—	1	3	—	—	—	—
Frederick.....	12	—	—	5	3	—	—	—	—	—	3	—	—	—	4	—	3	—	—
Washington.....	—	—	—	2	2	—	10	—	—	—	—	—	—	2	10	—	3	—	—
Allegany.....	2	—	—	2	7	—	7	—	—	—	2	—	—	—	4	—	—	—	—
Garrett.....	—	—	—	4	2	—	1	—	—	—	—	—	—	—	—	—	1	—	—
Montgomery.....	11	—	2	1	126	—	18	—	1	—	1	—	—	4	7	—	1	—	2
Prince George's.....	9	—	4	—	122	—	11	—	—	1	10	—	—	2	17	—	—	e-2	1
Calvert.....	1	—	—	—	2	—	—	—	—	—	—	—	—	—	1	—	—	p-1	—
Charles.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Saint Mary's.....	1	1	1	3	8	—	1	—	—	1	—	1	—	—	1	—	—	—	1
Cecil.....	2	1	—	80	15	—	3	—	—	—	—	—	—	—	1	—	—	—	—
Kent.....	—	—	—	—	32	—	25	—	—	—	—	—	—	—	—	—	—	—	—
Queen Anne's.....	—	—	—	1	46	—	1	—	—	—	—	—	—	—	2	—	—	—	—
Caroline.....	—	—	—	—	3	—	—	—	—	—	—	—	—	6	1	—	1	—	2
Talbot.....	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	3	—	1
Dorchester.....	—	—	—	—	7	—	—	—	—	—	—	—	—	—	4	—	7	—	2
Wicomico.....	8	—	2	—	3	—	16	—	—	—	6	—	—	—	4	1	20	—	1
Worcester.....	—	—	1	1	7	—	—	—	—	—	—	—	—	1	1	3	—	—	—
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	4	—	—
Total Counties.....	92	3	23	117	693	0	191	0	1	4	49	1	0	23	77	4	53		15
Baltimore City.....	91	0	14	4	193	0	105	2	0	2	40	0	0	24	112	4	391	e-2	16
State																			
May 28-June 24, '54..	183	3	37	121	886	0	296	2	1	6	89	2	0	47	189	8	444		31
Same period 1953.....	122	0	81	75	342	10	374	4	2	0	149	2	1	23	224	13	632		23
5-year median.....	292	1	113	—	350	4	210	5		7	63	3	3	37	234	25	566		26
Cumulative totals																			
State																			
Year 1954 to date.....	2839	9	250	589	10864	23	2444	6	1	11	1205	7	3	405	1073	82	3381		313
Same period 1953.....	2602	8	1370	256	1289	55	1731	8	2	2	2114	10	6	103	1212	77	3769		454
5-year median.....	2885	19	887	—	3965	35	1258	15		11	812	12	18	231	1377	237	3275		357

e = encephalitis infections
p = psittacosis
tv = typhus fever



Blue Cross - Blue Shield



THE BLUE SHIELD NATIONAL ORGANIZATION

R. H. DABNEY*

Early in the history of Blue Cross there was found to be a need for coordination of Plan activities on a national basis, and today such coordination for the 85 Blue Cross Plans throughout the country is provided through the Blue Cross Commission. Similarly, the activities of the 77 non-profit medical care Plans are now coordinated through an agency called Blue Shield Medical Care Plans—usually referred to as the Blue Shield Commission which is its governing body—with offices in Chicago operated jointly with the Blue Cross Commission.

Structurally, the Blue Shield national organization is composed of 30 Commissioners. Twenty-two of these are elected annually from the eleven geographical districts into which Blue Shield Plans are grouped, each district electing one commissioner who must be a Plan Trustee and one commissioner who must be a Plan Director. In addition, there are eight Commissioners-At-Large, one of whom is now appointed by the Council on Medical Service of the American Medical Association. The present composition of the Commission includes 18 doctors of medicine and 12 laymen.

Dr. L. Howard Schriver, a Cincinnati surgeon and a recent President of the Blue Shield Plan in Ohio, is President of the Commission and directs its activities through a six-man Executive Committee. A paid staff, under the supervision of Director Frank E. Smith, performs the administrative assignments, principally research, public relations, office and financial management, actuarial-statistical service, and inter-plan transfer arrangements. The Commission staff organizes national meetings throughout the year, usually in conjunction with Blue Cross, at which Plan personnel have an opportunity to exchange ideas and information on operating problems, such as enrollment, under-

writing, and public relations. In addition, meetings are held in the various districts to discuss national programs such as the transfer agreement and to elect the Commissioners.

Activities of the Blue Shield Commission are supported financially by the 77 member Plans which contribute dues prorated on the basis of local enrollment. As of December 31, 1953, these Plans had a total enrollment of just over 28,000,000 persons. Twelve Plans have enrollments of over 500,000 subscribers, the three largest being New York City's United Medical Service with 3,057,700, Michigan Medical Service (Detroit) with 2,974,000, and Medical Service Association of Pennsylvania with 2,641,470.

No two Blue Shield Plans are exactly alike, but all must conform to certain basic approval standards established by the national Commission. Among these standards are (1) approval by local state or country medical societies, (2) responsibility of the medical profession for the medical services included in the benefits, (3) free choice of physicians for subscribers, (4) preservation of the patient-doctor relationship, and (5) not-for-profit financial operation.

Of the 77 approved Blue Shield Plans, 60 now provide benefits on a partial service basis, with the participating physicians agreeing to accept a specified fee if the subscriber's income is below certain levels. Such income limits differ in various localities, now ranging (Individual and Family) from \$1,500 to \$6,000 per year. One Plan provides full service benefits without regard to the subscriber's income. Altogether there are about 122,000 physicians participating, or roughly 89 per cent of all doctors in private practice in the areas served by Blue Shield Plans.

Administratively, Blue Shield Plans operate either (1) in complete coordination with Blue Cross, (2) in partial coordination with Blue Cross (enrollment and billing functions), or (3) independently from Blue Cross. The majority operate as we do in Maryland, namely, as separate corporations with separate governing boards, but in complete coordination with

* Executive Director, Maryland Hospital Service, Inc., and Maryland Medical Service, Inc.

Blue Cross under one director and one administrative staff.

All Blue Shield Plans offer surgical benefits, and a majority now also offer in-hospital medical services either as a part of their regular contracts or under special riders. A few Plans have provisions for home-and-office medical care. Benefits for medical specialties vary widely, as do benefits for consultations and assistant's services.

As a coordinating agency on the national level,

the Blue Shield Commission serves an important function in guiding the growth and development of all Blue Shield Plans. Plans benefit through the regular services which the Commission staff provides, and the subscribing public benefits through the assurance that Plans which display the Blue Shield symbol and use the name *Blue Shield* have met definite prescribed standards and are operated on a non-profit basis under the sponsorship of the medical profession.

DR. MAGNUSON CRITICAL OF ADMINISTRATION REINSURANCE PLAN

The AMA Washington Letter, No. 66

Dr. Paul Magnuson, chairman of the 1952 Truman Health Commission, believes the administration's plan for reinsuring health plans might not accomplish what Congress would expect from it. Appearing before the House Interstate and Foreign Commerce Committee, Dr. Magnuson made these points:

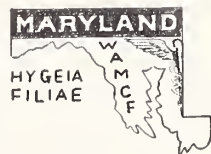
1. The plan is not specific enough, and would result in a mass of fine print in contracts when the administrators attempted to interpret congressional intentions. If it enacts the plan, Congress should state definitely what is to be covered.

2. The question of the indigent or the medically indigent should be left to the judgment of the local community; as far as he knows, Dr. Magnuson said, there are no indigent who cannot be taken care of in this country by existing local facilities.

During the questioning, Dr. Magnuson indicated that his concern is not with the financial soundness of any reinsurance idea, but with its potential usefulness.



Woman's Auxiliary Medical and Chirurgical Faculty



MRS. JOHN G. BALL, *Auxiliary Editor*

THE SEAL OF THE WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY

When our State Presidents have attended national meetings, they have felt that Maryland should have an identifying pin as most other states have. This year with the help of Mrs. George Yeager such a pin was designed. At the April Meeting, the President, Mrs. John G. Ball, wore the "President's Pin" with a small gold gavel, and presented it to Mrs. Albert E. Goldstein, the incoming President. A past-president's pin without the gavel was presented to Mrs. Thomas Christensen, organizer and first president of the Auxiliary. The pin is a gold replica of the state of Maryland enscribed with a half caduceus and the initials "W A M C F" and an added black enamel (Maryland) bar across the top.

Since a pin had been designed, the Auxiliary Board decided to have a seal made, similar to the pin, for use in the JOURNAL page and our stationery. The motto, "Hygiae Filiae," Daughters of Health, we felt, would show the interest of the Auxiliary in all matters pertaining to health. This seal is used for the first time in this issue of the JOURNAL.

STATE ANNUAL MEETING NOTES

The annual business meeting was well-attended. Delegates and county presidents representing our six organized counties, Baltimore City, Baltimore County, Prince George's, Montgomery, Washington and Wicomico were present. Members-at-large from Frederick, Carroll, Calvert and Anne Arundel counties attended.

The following officers were elected:

President—Mrs. Albert E. Goldstein (Baltimore City)

President-Elect—Mrs. Gerald W. LeVan (Washington County)

1st Vice-President—Mrs. Thomas C. Webster (Baltimore City)

2nd Vice-President—Mrs. David S. Clayman (Prince George's County)

3rd Vice-President—Mrs. William B. Long (Wicomico County)

4th Vice-President—Mrs. Thomas E. Wheeler (Baltimore County)

Parliamentarian—Mrs. Page C. Jett (Member-at-large)

Corresponding Secretary—Mrs. E. Elsworth Cook, Jr. (Baltimore City)

Recording Secretary—Mrs. Harold H. Mitchell (Montgomery County)

Treasurer—Mrs. Emil G. Bauersfeld (Montgomery County)

The following Committee Chairmen are announced by Mrs. Albert E. Goldstein: "Today's Health," Mrs. S. R. Wells, Hagerstown; Organization, Mrs. Gerald W. LeVan, Boonsboro; Public Relations, Mrs. George H. Yeager, Baltimore; Finance, Mrs. Whitmer B. Firor, Baltimore; Membership, Mrs. T. A. Christensen, College Park; Historian, Mrs. George E. Urban, Catonsville; Revisions and Resolutions, Mrs. Thomas C. Webster, Baltimore; Doctor's Day, Mrs. John S. Haught, Cheverly; Press and Publicity, Mrs. Thomas E. Wheeler, Randallstown; Bulletin, Mrs. S. Jack Sugar, College Park; Members-at-large, Mrs. James T. Marsh, Westminster; Co-Chairman, Mrs. Philip A. Insley, Salisbury; Legislation, Mrs. David S. Clayman, Riverdale; Civil Defense, Mrs. Arthur Baptisti, Jr., Hagerstown; Nurse Recruitment, Mrs. James P. Kerr, Damascus; Medical Education Foundation, Mrs. J. Carlton Wich, Baltimore; Convention Arrangements, Mrs. Charles H. Williams, Pikesville; Auxiliary Editor (MARYLAND STATE MEDICAL JOURNAL), Mrs. John G. Ball, Bethesda; Mental Health, Mrs. Harold H. Mitchell, Laytonsville.

The first memorial service for deceased members was held with a reading from Psalm 118.

Carnation corsages were presented to all members by Mr. Brown of Kloman Instrument Company, Baltimore. Favors of Soft-skin cream, pencils from Koontz Creamery, and Cavalier cigarettes were at all luncheon places.

Our speaker, Dr. John C. Krantz, Jr., charmed everyone with his superb delivery and wonderful speech, "The Simplicity to Wonder," which is on this page.

Mrs. Thomas Christensen, our organizer and first president, was presented with a past president's pin.

Mrs. Albert E. Goldstein received the president's pin and gavel and made her acceptance speech (see May JOURNAL) at this time.

The Hat and Fur Fashion show was very interesting. Our own members served as models and charming models they were! How did they ever learn those professional tricks of the modeling trade in a few minutes? It was really fun and we could all buy hats at half-price—the furs were beautiful but not half-price!

NATIONAL ANNUAL MEETING

The 31st Annual Meeting of the Woman's Auxiliary to the American Medical Association was held in San Francisco, California, June 21–24, 1954, with headquarters at the Hotel Fairmont. Maryland was proud to have Mrs. George H. Yeager serve as Constitutional Secretary. It is truly an honor for such a young Auxiliary to have a National Officer.

The meeting opened Monday at the Mark Hopkins Hotel, with round table discussions on Legislation, Mental Health, Nurse Recruitment, "Today's Health" and Public Relations. A tea honoring our President, Mrs. Leo Schaefer, was held later in the day.

The general sessions began on Tuesday, and Tuesday afternoon the Maryland State Report was read. A later issue of the JOURNAL will carry the full convention report.

The delegates representing Maryland were: Mrs. Gerald LeVan, Boonsboro; Mrs. James Kerr, Damascus; Mrs. A. E. Goldstein, Baltimore (Presidential delegate); Mrs. B. B. Kneisley, Hagerstown (Alternate).

THE SIMPLICITY TO WONDER¹

JOHN C. KRANTZ, JR., PH.D.²

When Benjamin Franklin was in England the parliament was composed of three estates—the Lords Common, the Lords Noble and the Lords Temporal. Sir Edmund Burke, pointing to the reporters in the gallery—the gentlemen of the press—referred to these men as the fourth estate, probably destined to play as great a part in the history of mankind as any of the other three. Burke was unmindful of the fact that there was in England in the person of Benjamin Franklin, a prototype, an exemplar of the new estate—the fifth estate, men of science, architects of progress who were destined to remold the character of man's life upon this planet.

It is altogether fitting and proper that to-day we should think together about some of these members of the fifth estate who have played an important role in human progress. Few, indeed, are those in any generation who by their scintillating intellects and indomitable curiosity have broken through the frontiers of scientific knowledge and achieved discovery; Discovery, "the increment of progress"; Discovery, "the

¹Presented at the Fifth Annual Meeting of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland, on Tuesday afternoon, April 27, 1954, in the Blue Room, Sheraton Belvedere Hotel, Baltimore 2, Maryland.

²Professor of Pharmacology, University of Maryland School of Medicine.

differential coefficient of the curve of knowledge." I know of no better way to characterize these men than to say that "they have the simplicity to wonder, the ability to question, the power to generalize and the capacity to apply."

Lowell expressed the spirit and service of science in these inspiring lines,

New experiences teach new duties,
Time makes ancient good uncouth,
He must onward still and upward
Who would keep abreast of truth.

Rudyard Kipling characterized that fine art of critical thinking when he penned,

I have six faithful, serving men.
They serve me till I die,
Their names are who, and what, and when,
And how, and where and why.

My story begins in 1664. Charles II sat on the throne of England. The reign of no other British monarch witnessed such an illustrious galaxy of Englishmen. To philosophy and literature this era gave John Locke and Samuel Pepys; poetry was enriched by the advent of Milton and Dryden, and the names of Isaac Newton and Robert Boyle were inscribed upon the scroll of science. The architect, Christopher Wren, was contemporaneous with this distinguished group. Wren suggested to Boyle that if he could insert a quill into an animal's vein he could inject medicine or poison at will directly into the animal's circulation. Owing to the brilliance and resourcefulness of Wren, who at 24 was appointed Gresham Professor of Geometry at Oxford, Boyle was prompted to try the experiment. A dog was lashed to a table in the warden's dwelling at Wadham College. One of the superficial vessels of the leg was exposed and a quill inserted directly into the vessel and ligatured. By means of a syringe, an infusion of opium was injected. With bated breath the two investigators watched the animal slump into a deep narcosis. Inspired by the success of this experiment, the architect and chemist transfused blood from one dog to another. A new era in medicine was to be established—the quill became the precursor of the hypodermic needle which has made available as medicinal agents a host of substances which would otherwise be without therapeutic merit.

In 1665 the experiments were precipitously interrupted. The plague in London had reached its peak. Wren was off to Paris. The flamboyant Gothic architecture captured the imagination of the sagacious young scientist. Paris was building and Wren was a keen observer. In 1666 London was razed to the ground by the great fire. Hardly had the ashes cooled when Wren returned to aid in rebuilding a new London. And thus this scientist became a distinguished architect. As you stand in St. Paul's Cathedral and read the timeless epitaph, "If thou seek his monument, look about thee," you can feel the spirit of the genius of Wren, a man with the simplicity to wonder, the man who gave to medicine the art of transfusion and the concept of the hollow hypodermic needle.

The year is 1790, the scene is Paris, the thunder of the revolution shakes the earth. Yet in the quiet and calm of his laboratory Antoine Laurent Lavoisier is putting a

great question to nature. He has been told that when substances burn they lose a mysterious material called phlogiston. Lavoisier did not believe it; he asked, "How do you know that?" "If phlogiston exists," said Lavoisier, "I shall get it and weigh it on the balance and compute it by mathematics, if I cannot weigh it or compute it by mathematics, it does not exist." And thus with this spirit of wholesome inquiry he showed that burning was not the dephlogistination of matter but a combining with oxygen. "And then what about breathing?" inquired Lavoisier. He described the oxygenation of blood in the lungs and developed the biological chemistry of the pulmonary circulation described by Servetus.

But Lavoisier was an aristocrat and the revolutionary rabble was in the saddle. He was snatched abruptly from his experiments and tried before the revolutionary tribunal. Robespierre drew his finger around his neck and declared, "The republic hath no need of savants." On May 2, 1794, third in a line of 28, Lavoisier rode in the tumbril over the cobbled streets of Paris to the Place de la Concorde. The guillotine fell. Lagrange very trenchantly commented, "It took but a minute to sever that head, France will be a century in producing another like it." This statement was prophetic, because France did not produce another citizen like Lavoisier until the advent of Louis Pasteur. With the simplicity to wonder, he has been fittingly called the "father of modern chemistry."

The charming widow of Lavoisier escaped the guillotine. She married Count Rumford who settled in London and founded the Royal Institution. It was here that Sir Humphrey Davy worked. It was here that Michael Faraday, the book binder's boy, came to hear Davy's lectures. In this institution Faraday made benzene which has molded man's destiny on this planet. Here Faraday broke the lines of magnetic force around a magnet and induced an electric current. On this occasion Gladstone inquired of Faraday, "Suppose you have induced a current into that wire, what of it, Mr. Faraday?" Faraday replied, "Some day you will be able to tax it." Toward the end of a career replete with discovery, someone inquired of Sir Humphrey Davy, "What was your greatest discovery?" Unhesitatingly he replied, "My laboratory boy, Michael Faraday." That spirit of inquiry, the scientific attitude again had helped to carve the destiny of mankind.

Toward the end of the 18th century one of the most distinguished societies of England was the Lunar Society. Among its members were Erasmus Darwin, grandfather of the immortal Charles Darwin, James Watt, who discovered the power of steam, Joseph Priestly, who discovered oxygen and nitrous oxide, and William Withering, the "flower of English physicians." The principal of Brazen Nose College was seriously ill with dropsy. The standard treatments of the day had failed. The herb concoction of Mrs. Hutton of Shropshire was tried and produced dramatic results. This information reached Withering, who had the simplicity to wonder about it. He sought out Mrs. Hutton and for a few golden sovereigns secured the formula for the herb concoction of many ingredients. Carefully and experimentally on turkeys he tried the activity of the various herbs, ultimately arriving at the conclusion that it was the leaf of the purple foxglove that was responsible for the beneficial results. Those who are physicians in this audience can hear him as he said, "With this drug we can regulate the pulse at will." Little did he realize the importance of that

timeless paper published in 1785, "The Foxglove and an Account of Its Medicinal Properties." Withering, the busy clinician; Withering, the distinguished botanist; Withering, the connoisseur in mineralogy, would have been lost to posterity and the same tomb which covers his body would have covered his fame also, if he had not had the simplicity to wonder about and the ability to question an old herb concoction.

The year 1929 was a great one for the human race. It was at that time that Alexander Fleming discovered that the mold, penicillin, inhibited the usual growth of certain bacteria in culture dishes. It occurred to him that molds produced a substance inimical to the growth of bacteria. He made extracts of the mold-growth material and injected them into mice infected with various bacteria and was able to save their lives. Actually this experiment of Alexander Fleming reminds one of those words of Louis Pasteur, who said, "In the field of observation, chance favors only that mind which is prepared." Fleming turned to the medical profession and said, "Gentlemen, I have a drug made from a mold that will be useful for the cure of infectious disease." They turned a deaf ear to him. A decade passed.

It was a foggy, dreary, cold day in February, 1940, that a British bobby who had cut himself while shaving went to Radcliffe Hospital in Oxford with an infection of the blood. The whole gamut of sulfonamide drugs was tried but he got progressively worse. In the adjoining room Chain and Florey were repeating the experiment of Alexander Fleming. They injected their penicillin extract into the British bobby and his fever dropped precipitously. He appeared to be getting well but they were out of the drug and the British bobby died. These astute workers saved the urine from the now dead British police officer and extracted from it penicillin, with which a few days later they saved the life of a boy who had a septicemia resulting from an infected hip. The cure was dramatic. The evidence was overwhelming that these British workers had obtained a drug useful in the treatment of infectious diseases.

Soon penicillin was made by the pharmaceutical manufacturers of this country and placed in the hands of our Armed Forces and then given to the civilian population. After 14 years we look back and see that for the first time on this planet man has an anti-infective drug useful against many deadly organisms which is without any marked toxicity to the human being.

Enough has been said to show that this same science which has brought so many benefits to the human race has at the same time given us the terror of a new fear, that of atomic annihilation. Come with me, if you will, to the capital of California. We are approaching one of its massive buildings. As we enter that door a caption above it catches our eye, "Give me men to match these mountains." What this old world of ours so desperately needs are men and women with the eternal goodness of the Golden Rule in their hearts to match the scientific greatness of this, our hour.

*University of Maryland Medical School
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Book Reviews

Basic Bacteriology—Its Biological and Chemical Background. Carl Lamanna, Ph.D., Associate Professor of Bacteriology in the Johns Hopkins University School of Hygiene and Public Health, and M. Frank Mallette, Ph.D., Associate Professor of Biochemistry in the Johns Hopkins University School of Hygiene and Public Health. Foreword by James M. Sherman, Ph.D., Professor of Bacteriology, Cornell University. Copyright 1953. The Williams and Wilkins Company, Publishers. 677 pages. Illustrated. \$10.00.

The teacher responsible for the direction of graduate education and research in bacteriology is confronted most often with the student whose background is inadequate in either chemistry and physics or bacteriology. Furthermore, at the undergraduate level, there is little integration of the basic sciences of chemistry and physics with bacteriology.

While the lack of a satisfactory background in chemistry and physics may be corrected in the graduate program of study the failure to integrate these sciences with bacteriology often remains as a problem. The textbooks available in bacteriology are either elementary or advanced with respect to content and either quite generalized or highly specific with respect to viewpoint. *Basic Bacteriology* does more than fill the void between the extremes, it provides a solution for the problem of integration. For the medical student it is an excellent reference source for basic bacteriology.

This text provides for the graduate student a comprehensive and integrated foundation in basic bacteriology.

E. S.

A. M. A. SERVICE MEMBERSHIP

During the past few years, there has been considerable confusion concerning the membership status of physicians entitled to Service Membership in the American Medical Association.

The following medical officers are eligible to hold *Service* Membership in the A. M. A., which type of membership does not require payment of A. M. A. dues or membership through a constituent society:

Regular U. S. Army

Regular U. S. Navy

Regular U. S. Air Force

Regular U. S. Public Health Service

Veterans Administration (full-time career officers)

Indian Service (full-time career officers)

Retired medical officers of the above six services provided they do not engage in active practice.

Service members cannot be counted by a constituent association toward A. M. A. delegate representation. The number of delegates from the constituent associations is proportional to the number of *Active Members* of the American Medical Association in the respective associations.

A physician can hold only one type of membership in the A. M. A. at any one time. A Service member, for example, is eligible to *Active* A. M. A. membership only after his name has been removed from the Service Membership category.

A.M.A. NEWS RELEASE—WASHINGTON OFFICE

THE MONTH IN WASHINGTON

Washington, D. C.—The controversial health reinsurance issue has come back into prominence, and under conditions that make the whole question about as complicated as it can get. The bill would have the federal government underwrite voluntary health insurance plans if they agree to experiment with risks not usually covered.

Although this measure is a major part of President Eisenhower's health program, it became bogged down in the House Interstate and Foreign Commerce Committee when widespread opposition developed. Then the committee chairman, Rep. Charles E. Wolverton (R.-N.J.), turned to one of his favorite subjects, a plan for federal guarantee of private loans to health facilities for construction and equipment. This bill, however, was not supported by the administration.

In an effort to placate the opposition, Mr. Wolverton offered to eliminate a number of objectionable features from the mortgage guarantee bill. At the same time there were reports that he proposed to merge this bill with the administration-supported reinsurance bill. Meanwhile, Henry J. Kaiser made two special trips to Washington to help out his friend, Mr. Wolverton, by putting his weight behind the mortgage loan idea. That was not surprising, inasmuch as Mr. Kaiser had helped to draw up the bill, which would greatly benefit health centers such as those started on the West Coast by the Kaiser Foundation.

Mr. Kaiser, saying he was producing a film to promote the mortgage loan plan, went to the unusual extent of making a direct appeal to Washington news correspondents to write favorable copy about the bill.

While these Wolverton-Kaiser maneuverings were taking place on the mortgage bill, it became apparent that President Eisenhower was not ready to abandon the reinsurance idea. He called a number of executives of major life insurance companies to the White House to try to impress them with the merits of reinsurance and in other ways indicated he still wanted to see the bill passed this session. Secretary Hobby, whose original testimony for reinsurance had been restrained, also joined in the last-minute campaign. But it appeared the tangle might be too complicated even for Mr. Eisenhower to unravel before adjournment.

Most other parts of the Eisenhower health program were moving through Congress, even though some were off schedule. (Of the major bills, AMA opposes only reinsurance.) Legislation to expand the Hill-Burton hospital construction program cleared what might have been a serious obstacle when it was reported out by the Senate committee. Compared with the House bill, the Senate bill gave more discretion to state health authorities in use of funds for constructing facilities for the chronically ill, for nursing homes, and for health centers. However, the Senate would require that funds earmarked for rehabilitation centers be used for the stated purpose. The Senate also would rule out the possibility of U. S. grants to centers devoted solely to treatment. Unless the facility could qualify as a diagnostic center, or a diagnostic-treatment center, it could not be eligible under the Senate bill. This safeguard was not in the House bill.

Of the remaining legislation of interest to the medical profession, the status at this writing was about as follows:

The doctor draft amendment, to strengthen Defense Department's hand in dealing with physicians who might be security risks, had passed the Senate, been reported by the House committee, and was almost a law. Also about to be enacted was a provision liberalizing medical expense deductions from taxable income. The long-dormant bill to transfer responsibility for Indians' health matters from the Indian Bureau in Interior Department to Public Health Service in the Department of Health, Education, and Welfare was pointed toward enactment,

but might possibly be held up by objections of Senators from a few western states. The Interior Department had dropped its original objection.

The House-passed social security bill, with the compulsory coverage of physicians eliminated, was before the Senate Finance Committee, where anything could happen. Two bills of medical interest already had been passed by both houses and signed into law. One prohibits the shipment of fireworks into a state where fireworks are illegal, and the other relieves Army medical officers of the technical responsibility for supervising preparation of food.

A reassuring note was sounded by President Eisenhower when he forwarded to Congress the controversial International Labor Organization convention on minimum standards of social security with a recommendation that it not be ratified. His message said most of the points—including a suggestion for socialized medicine—were not proper subjects for the Congress to deal with.

* * * * *

INTERGOVERNMENTAL COMMISSION SETTING UP HEALTH COMMITTEE

The A. M. A. Washington Letter, No. 69

Federal-state responsibilities in the field of health will be studied by a special committee now being formed by the Commission on Intergovernmental Relations. The 10-man group will include three commission members. Four research organizations are also reviewing the administrative, fiscal, and political aspects of federal grants-in-aid programs, and are expected to report to the commission within the next few months. Formerly headed by Clarence Manion, the commission now is under the direction of Meyer Kestnbaum. George C. S. Benson, commission research director, called his group's study division of health responsibilities "the most substantial program ever undertaken in the field" in a speech before the U. S. Chamber of Commerce.

* * * * *

PRESIDENT AGREES TO \$25 MILLION HILL-BURTON INCREASE

The A. M. A. Washington Letter, No. 70

President Eisenhower will recommend that Congress increase these three health program appropriations for fiscal 1955: Hill-Burton hospital construction from \$50 million to \$75 million; vocational education from \$17.5 to \$18.6 million; and Public Health Service grants (tuberculosis, venereal disease, etc.) from \$19.4 million to \$22.8 million. Announcement that the administration would not insist on holding to the Budget Bureau's figures was made by Senator Thyne before a session of the appropriations subcommittee of which he is chairman. The new figure for Hill-Burton would be \$10 million higher than the current appropriation, but the other two changes would in effect bring the programs up to the current level of spending. The Hill-Burton appropriation would be applied only to grants for hospitals; legislation passed by the House and pending in the Senate Health Subcommittee to extend the Hill-Burton program would require additional appropriations. The administration made no mention of increasing the funds for vocational rehabilitation, inasmuch as legislation to expand this program is pending in House and Senate. If the legislation is adopted, vocational rehabilitation appropriations would be increased from \$19.5 million to \$23 million or more.

Maryland STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 3

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TRANSACTIONS

One Hundred Fifty-Sixth Annual Meeting

MEDICAL AND CHIRURGICAL FACULTY
of the State of Maryland

1211 Cathedral Street, Baltimore, Maryland
April 26, 27, 28, 1954

SCIENTIFIC SESSIONS

Tuesday and Wednesday, April 27, and 28, 1954

BUSINESS SESSIONS

April 26, 27, 28, 1954

ALSO

SEMIANNUAL MEETING, OCTOBER 6, 1953
50th Anniversary of the Montgomery County
Medical Society

BUSINESS AND SCIENTIFIC SESSIONS
Bethesda, Montgomery County, Maryland

FOR COMPLETION OF TRANSACTIONS

See Volume 3, No. 9, September, 1954, Maryland State Medical Journal, for completion of 1954 Transactions.

The Membership Roster, which is a part of the Transactions, was published in Volume 3, No. 5, May, 1954.

Scientific Sessions

OUR RELATIONS WITH THE PUBLIC¹

BENDER B. KNEISLEY, M.D.²

No one who is familiar with the history and tradition of this fine old Faculty, in existence since 1799, could help but feel greatly honored in being selected to be its President. As one who has always made an effort, for some thirty years, to maintain an active interest in our State Society, my heartfelt gratitude and appreciation goes out to the members of this organization for their recognition.

Our relations with the public is an exceedingly important aspect in the practice of medicine. It is here now, and it might be instantly added, always has been. To-day, since 1946, when the American Medical Association first started its organizational effort in public relations, we hear much, so much, and as some of us think, too much, about this "*thing*" called public relations. One would not expect the medical profession, as has always been customary with doctors, to agree on methods of approach and execution of plans for better public relations. But one can say, we think, that there is a common agreement in that we should have good public relations. Therefore, we are all against bad public relations. Many of us recall the story, told many times perhaps, about one of the Presidents of the United States, the late Calvin Coolidge. When asked by his wife, after returning from Church one Sunday what the minister said about God, his answer was that,

"he was for Him." "And what," the wife asked, "did he say about the Devil?" "He was against him," answered the good President. So, we all are for good public relations. Our only difference, one feels, is in our attitude and approach to the problem.

From what we can gather in recent years coming from voluminous written articles, discussions and personal conversations, there are three main types of approach—First, there is the ultra conservative viewpoint, the status quo, or what might be better termed the "let it alone," idea. These men believe that if we give perfect service to our patients, always live up to the precepts of Hippocrates in word and deed, there will be no need for all the furor about public relations. Unfortunately, such Utopian conditions do not, nor have they ever existed. One feels that he must reject this attitude, although idealistically, it has much to offer. . . . The second type of approach is the extreme one. Those in this category believe in going all out with somewhat high pressure publicity, all types of plans and methods of winning the public to our side. It has the scent of a big, paid, publicity campaign to buy public favor. This category, we feel also, we must reject. . . . The third viewpoint, held by a very large group of doctors, is the "middle of the road one," moderately conservative or a wee bit to the left or right of the center. Although your speaker is definitely committed to this third and last viewpoint, he certainly under no circumstances, questions your right to differ.

Now why, we ask, why is there this hue and cry for better public relations? Is it really needed?

¹ Presidential Address, presented at the One Hundred and Fifty-sixth Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, on Tuesday evening, April 27, 1954, in Osler Hall, 1211 Cathedral Street, Baltimore 1, Maryland.

² President of the Medical and Chirurgical Faculty of the State of Maryland.

Are we still the unassailable profession? Can we do no wrong? Alas, we come out of a long period of lethargy, rub our eyes, and inquire. We find that many people can not get emergency service. Some people think they are overcharged; there are misunderstandings due to a lack of public education; lay and voluntary public health groups have had no cooperative medical leadership. The press relationship has not been what it should be and doctors get a poor press. Many people do not have a personal or family physician. And so we find many of the answers to these inquiries surprise us. But we know that these conditions exist, exaggerated or not, and the attitude of denial will not suffice. So, what to do?

We set about mending our own fences and offering the public and ourselves a positive program based on offensive as against defensive action. Today, a vital program capable of producing successful results, should include as its necessary objectives, . . . the improvement of medical services, . . . public education, and the building of medical leadership in all those fields where Society needs and expects doctors to lend their experience and knowledge in the improvement of man's lot.

No person because of his economic status or otherwise should be denied good medical care. All doctors of course sincerely believe and are dedicated to such. But many physicians are busy, some are away from town or city and on some occasions they can not be reached when an emergency arises. Strangers move into town and do not contact a physician for future family care. Word got abroad the country-land by conversation and by press articles that it was difficult to get a doctor in an emergency. Most cities, larger towns and some smaller communities now have an emergency medical service, sponsored by the local society group and taken care of by a roster of rotating doctors. They give emergency service on a twenty-four hour basis. The public appreciates such a service and such action has eliminated the old chronic complaint

of not being able to get a doctor. Hagerstown, Maryland, has had an emergency service in operation since 1951. Last year three hundred and twenty-five calls were processed through the answering service. True . . . some calls were not necessary, but the large majority were, and it has been found that by and large the public is a fairly good judge of what an emergency is. Many of these calls were made because the family had recently moved into town, and had not made contact with a physician to be their family doctor. If every family had a personal or family physician, the emergency load could be greatly reduced. A recent American Medical Association survey showed that there were over 600 emergency medical call plans in operation in the United States.

The American public should be shown the desirability and the value of having their own personal or family doctor. There is much comfort and a feeling of security on the part of a family that has a regular personal physician. Not only do the members of the family feel that he will take care of them in an emergency, but that they can go to him for medical counsel and advice. They feel that he will guide them into specialized services when such services are indicated or when diagnostic problems arise. And we must not overlook the fact that a good conscientious physician is the best asset the profession has in good public relations. He is right at the very grass roots of our endeavor.

The reading public is much interested about things medical. Witness the public press, which in many instances has staff writers for medical subjects alone. Many of these articles are praiseworthy and follow along orthodox medical concepts. But sometimes medicine is thrown in a bad light by careless free lance writers who do not always get their facts straight, and who for color may dramatize. The effect is more at a sensational reader interest story. We do not desire to be "white washed," but we only plead for truth and honesty. We do not claim to be always in the right. Great strides have been

made in closer cooperation with the press. In many cities and states codes of cooperation have been drawn and much better understanding exists between medical men and the press. A friendly spirit and a willingness to sit down around the table and discuss our mutual problems are great aids in solving unsatisfactory relations. Any day, any time, the newspaper man will have a story. He needs our help for the facts. We should be willing to assist him when such help does not violate our accepted code of ethics. The Press, Radio and more recently Television have put down the welcome mat to medicine. We are showing and will show our appreciation by constructive contributions to such media, for it is here that our opportunities for giving the public the true side of medicine lies.

One of the most outstanding contributions given too little notice, we think, has been the activities of the State and local Women's Auxiliaries. Their programs have not only featured better intra-professional relationships, but have added much in better public understanding of our problems. Recently a public relations man said that he thought the annual dues of these Auxiliaries were quite low. Knowing what a fine job they have already done for our cause, perhaps by doubling the dues their effectiveness could be doubled or even tripled. Husbands . . . will please vote in the affirmative!

Lay organizations and voluntary health organizations should have our cooperation in giving medical leadership and education where

and when needed. Speaker bureaus or speaker committees in Societies are a great help to those organizations in their efforts to educate the public in things medical. Our leadership should implement the activities of voluntary health insurance organizations and we should understand and explain to our patients the advantages of policies with Blue Shield and Blue Cross and other voluntary companies. . . . A discussion of fees is in order and many misunderstandings could be avoided by a frank discussion of such. There are many other "frills" if you please, attached to the broad subject of public relations, but it seems to your speaker that we should concentrate on the real needs as it affects us or as others might think, as to the needs in their community. And when we take a positive program in the educative field or the service field, we should do that and do it well. Such would be more realistic than to be inoculated with a whole mass of promotional ideas and be drowned while learning to swim.

In closing . . . I wish to say that we must do more than practice good medicine. That is not enough, important as it may be. Nor are good Public Relations enough. If we are to have our freedom in America, we will have to speak out. This is the time for men of medicine to take their civic responsibilities in all sincerity. In such an old and illustrious, yet so vital an institution as the Medical and Chirurgical Faculty of Maryland, one has an abiding faith.

*148 West Washington Street
Hagerstown, Maryland*

SEMIANNUAL MEETING

THURSDAY, SEPTEMBER 30, 1954, HAGERSTOWN, MARYLAND

The Chairman of the Committee on Scientific Work and Arrangements, Dr. Beverley C. Compton, has met with the committees of the Washington County Medical Society, and an outstanding Semiannual Meeting has been arranged for Thursday, September 30th at the Hotel Alexander in Hagerstown. Programs will be mailed about the first week in September.

Some of the members of the Washington County Medical Society assisting in planning this program are: Dr. Archie R. Cohen, Dr. S. Earl Young, Dr. Ernest F. Poole, Dr. William T. Layman, Dr. Richard V. Hauver, Dr. Lester M. Shaffer, Dr. Stanley H. Macht, Dr. Sidney Novenstein, Dr. L. H. Brumback, Dr. O. H. Binkley, Dr. J. W. Layman, Dr. Charles L. Mowrer, Dr. Peregrine Wroth, Jr., Dr. W. D. Campbell, Dr. R. S. Stauffer, Dr. Victor D. Miller, Dr. W. Hamilton Smith, Dr. Homer E. Tabler, Dr. W. Ross Cameron, Dr. Frederick D. Dove, Jr., Dr. Lloyd A. Hoffman, Dr. R. V. Campbell, and Dr. Robert F. Keadle

As this Journal goes to press, all arrangements have not been completed. So that you may know the highlights and plan to attend, the outline of the program is being published in this issue of the Journal.

PROGRAM

BUSINESS SESSIONS—WASHINGTON COUNTY HOSPITAL

COUNCIL, Pangborn Hall, Nurses Home.....9:00 a.m. to 9:30 a.m.

HOUSE OF DELEGATES, Dorsey Hall.....9:30 a.m. to 12:00 noon

HOTEL ALEXANDER—HEADQUARTERS

REGISTRATION.....9:00 a.m. and throughout the day

LUNCHEON.....12:30 p.m.

GENERAL AND SCIENTIFIC MEETING, Ballroom..2:00 p.m.

DIAGNOSTIC PROBLEMS IN THE THORAX. JOHN M. T. FINNEY FUND LECTURE.

Julian Johnson, M.D., Philadelphia, Pennsylvania.

DIFFICULTIES IN GERIATRIC DIAGNOSIS. WILLIAM ROYAL STOKES MEMORIAL LECTURE.

Edward J. Stieglitz, M.D., Washington, D. C.

RECEPTION, Ballroom.....4:30 p.m. to 6:00 p.m.

(Guests of the Washington County Medical Society.)

WOMAN'S AUXILIARY, Chalet Room.....10:00 a.m. to 12:15 p.m.

ENTERTAINMENT.....Tours, Golf, and Bridge.

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OUR GROWING RESPONSIBILITIES TO THE AGED IN OUR MIDST¹

RICHARD A. KERN, M.D.²

There is nothing new about the problems which an aged individual poses for those around him. The Methusaleh family must have known all about them. But it is only in the last 25 years that those problems have been snowballing to alarming proportions, both because of the rapid increase of the aged in our midst and the shrinking ability of their families to care for them.

When Cicero wrote his *De Senectute* 2000 years ago, the average life span in Rome was 23 years. In 1000 A.D. in England it was 35 years. In 1900 in the United States it had increased only to 47 years. But to-day an infant at birth has a life expectancy of nearly 70 years.

As a result, the aged are rapidly becoming a larger fraction of the population. The census of 1850, showed that only 2.5 per cent of Americans had reached the age of 65. In 1950, 8 per cent were over 65, and if the trend continues, then in 1980, these oldsters will constitute 14.5 per cent of our population.

In some states, and especially some cities, the trend has been even more rapid. For example, in Maine, New Hampshire, Vermont and Massachusetts (to mention only a few) over 9 per cent of the people were past 65 in 1950, and in that year the oldsters made up 22.2 per cent of the permanent residents of the city of St. Petersburg, Florida.

By the sheer weight of their numbers the aged are claiming our attention with rapidly growing problems in many fields of human endeavor: not just in medicine, but in industry and politics, in religion and philosophy, in our basic concepts of government and human rela-

tions. But no matter which field we examine, it is first and foremost the economic factors involved that are forcing the issue. Therefore all of us, regardless of profession or sphere of activity or interest, must interest ourselves in the nature, and apply ourselves to the solution, of the economic problems of our aged. Let me point out some of these problems—I regret that I have no pat solutions.

Thrift is not a common virtue. A scant 5 per cent of those over 65 have saved enough to be self supporting. Another 25 per cent are still at work. Therefore 70 per cent are being supported wholly or in part by others.

Now consider how big this support problem is today, and how much larger it may be in a very few years. Those over 65 now comprise 8 per cent of the total population: but they are 11 per cent of those over 18: that means there are today 8 workers between the ages of 18 and 65 for every oldster. But in 1980, 24 years from now, those over 65 will be 20 per cent of those over 18, and there will be only 4 workers for every oldster.

Our *basic economic needs*, regardless of our ages, can be grouped under three headings: *Subsistence* (covering basic essentials of food, clothing and shelter); *Care* (providing unskilled help for those unable to help themselves: such as the very young, the infirm, the temporarily or permanently handicapped); and *Treatment* (the costs incident to illness or injury).

Let us review how these needs of our aged have been met in the past and are being met today.

Subsistence is best provided by the oldster himself who has saved a competency, or, better still, who can continue to work. The sweetest bread is that which you earn in the sweat of your own brow; the bitterest is the bread of charity, no matter who dispenses it.

In the absence of self-support, most of the

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aged used to depend for subsistence upon their children. But today families are smaller, and there is no room for a parent in a tiny house or apartment. Among 2000 applicants for admission to a home for the aged, 95 per cent had no living children, and those of the rest were too old or infirm, rarely unwilling, to help their parents.

To an increasing degree, *Government* has therefore been stepping into the breach with old age pensions and social security insurance. Such financial aid has the great advantage of permitting the aged to continue to live in their own homes. Unfortunately, 26 per cent of men between 65 and 69, and 51 per cent of women in that age group are widowed; yet many, especially old women in groups of 2 or 3, have solved their problem by pooling their resources and forming what the social economists call the "pseudo-family."

But such governmental programs of financial aid have some serious defects. *State old-age pensions* depend on the wealth of the state that pays them. In 1948, they ranged from a low of \$18.79 a month in Mississippi, to \$70.63 in California. Yet at that time the basic cost of living per couple per month was \$125 to \$152. The pensions therefore fell short of providing even the barest subsistence. But to raise them accordingly would be too expensive. A law passed by California in 1948 to grant a \$75 monthly pension at age 63 was changed a year later by raising the age to 65, because of the threat to that state's solvency. *Social security programs* as well as the State pension plans have the additional serious defect of not being on a sound actuarial basis, but existing on a pay-as-you-go plan, dependent on current tax income rather than on established cash reserves.

Private pension plans are rapidly becoming an important means for providing subsistence for the aged. In 12 years those covered have increased from 600,000 to over 12,000,000, and the coverage is financially adequate. They are of two types: the annuity purchased by an in-

dividual from an insurance company, and the pension plans set up by industries for their employees. Both are on a sound actuarial basis.

But the industrial pensions have this important weakness: If an industry gets into financial difficulties, not only in periods of general business depression, but under conditions affecting a single plant or industry, such as a local disaster, or a new invention that makes an important product obsolete, a small factory may have trouble in meeting its pension payments, unless there are strong cash reserves.

All pension plans must face yet another serious threat: *inflation*. What will the hard-earned premium dollars of today buy as pensions in future years? None are so cruelly hurt by the shrunken value of an inflated currency as the aged on a fixed income from savings or a pension.

So far we have been dealing only with the cost of subsistence. That cost is more than doubled when, because of infirmity, *Care* becomes necessary. The salary of a "practical" nurse or unskilled attendant, plus the subsistence of the nurse, will account for that. Care for the oldster is cheap only when given free by relatives in the home or by attendants to larger groups in an institution.

Homes for the aged have therefore been provided by Government at the local level to give care to the infirm aged at the expense of the taxpayer. But such institutions have some obvious shortcomings. There is only one ticket of admission: indigency; the inmates have no choice in the selection of their company. The standard of living is kept down to the lowest possible level: the taxpayers see to that. Such "homes" all too often deserve their earlier name, the "Poor House."

On the other hand, *homes privately supported* by special groups such as a religious body, a fraternity or a trades-union, are ministering to a larger number of aged than ever before. They shelter guests with common backgrounds and interests. They provide generously not only for

body, but for mind and soul, because their sponsors take pride and personal interest in inmates and institution. Visitors in county "homes" are a rarity, but they come by the hundreds, even thousands, to these "group" homes. The most eloquent testimony to the general excellence of the services rendered by these institutions is seen in the growing waiting lists of their applicants.

When *Treatment* for illness must be provided in addition to subsistence and care, then costs rise to astronomic figures, because this calls for hospitalization, the most expensive item in any person's experience. The aged, who are least able to pay for it, are the very ones who need it most. In 1940, Dublin reported that the policy holders of the Metropolitan Life Insurance Company average 6.9 days of disabling illness per year but the policy holders over 65 were ill 35 days a year. In a home for the aged with which I have been connected, the guests, whose average age is 79 years, are in bed because of illness for 91 days each year.

This is why the beds of our general hospitals are largely filled with aged patients. Most of these have chronic ailments and therefore require chiefly nursing care, some medical attention and little or nothing of the elaborate diagnostic and special therapeutic service which those hospitals are prepared to give and which are so largely responsible for the high cost of maintenance of those institutions.

There is a crying need for a new type of hospital for the convalescent care and rehabilitation of patients, especially the aged. It would require little in the way of expensive laboratories, radiology departments and surgical equipment, and therefore could furnish service at a much lower per diem cost. It should be located next door to a general hospital, or, in a small community, could be a separate building of the hospital, so that its patients could be served, when necessary, by the staff and facilities of the general institution, but on a separate cost-accounting basis.

If there has been trouble in finding the money to pay for *subsistence* and *care*, it is as nothing in comparison with that to meet the cost of *treatment*. Since illness requiring hospitalization is of the nature of a catastrophe in the life of any individual, it is only logical that he should prepare to meet that cost, as he does other possible catastrophes, by some form of insurance.

So it is, that the aged in our midst, by reason of their numbers and their need, have suddenly confronted us with an economic problem that in turn threatens to change our political structure and our basic philosophy of government. The proponents of the Socialized State have seized upon it as the major first step in that direction by calling for *compulsory* health insurance. We of the Medical profession have borne the first brunt of the attack and thus far have held the line. In the meantime, *voluntary* insurance plans, such as Blue Cross, Blue Shield, and various others, have grown both in the numbers protected and the degree of coverage to the point where their ability to meet the problem seems surely predictable. Already 92,000,000, or 61 per cent, of our citizens have some form of such protection. But the struggle is only in its beginnings. Therefore, it is germane to this presentation to call attention to some basic facts in the matter.

The *cost of hospitalization*, the thing for which the patient gets billed, consists of two things: the charge by the hospital and the physician's services. Most laymen think that the doctor gets most of that money, and are therefore quite ready to side against the medical profession in schemes to combat the high cost of "medical" care. We must inform the public that the doctor's share is only a small fraction of that cost.

Compulsory health insurance is basically a form of taxation. It could produce for the government huge sums of revenue that could all too easily be diverted to pressing current needs, leaving eventual benefits to the insured to be raised out of future tax levies. Government

would certainly not subject itself to the same stringent controls that delimit the operations of private insurance companies. Nor would a government program be administered as economically: there are numerous examples in many fields, but the cumbersome bureaucracy of every compulsory system in other lands is the best proof.

Please be reminded, too, that in Great Britain compulsory health insurance was the first and irreversible step in the direction of state socialism.

But we are concerned at the moment with economic problems. It is a basic economic principle that the *standard of living of a country is a direct function of the total production of its people*. If more and more aged must be supported by fewer and fewer workers, then we are inevitably faced with a lower standard of living, unless our production per individual increases, or more old people stay at work: the latter is in my opinion by far the better plan.

Enforced retirement at an arbitrary age is for obvious reasons a necessary expedient in many occupations and walks of life. But its extension to every field of human endeavor and its inflexible enforcement in most fields constitute a major stupidity in current practice. It is an absurd assumption that a man possesses a 100 per cent working capacity to the last day of his 64th year and none whatever on the following day. First, industry is foolish in expecting the aging man to work at top speed, and we physicians often fail to advise him against it, and so contribute to his premature break-down. Then, by retiring him at 65, industry deprives itself of the worker's greatest asset: wisdom; wisdom comes only with experience, and experience only with years. But above all, it robs the worker of his finest means to happiness.

Here is a major challenge both to *industry* and to *medicine*: to industry, in making rules more flexible to make health and strength as well as age the criteria that govern retirement, and in providing for those, too old for more strenuous effort, new kinds of employment where they can

work at a slower pace, for shorter hours and less pay, but needing less pension, and the happier for their continued usefulness; to *medicine*, in striving, not only to prolong life, but to preserve vigor of mind and body as close to the end as may be.

It has already been intimated that there are *political problems* presented by our oldsters. They now comprise 12.5 per cent of those over 21, the voters, and by 1980 that proportion will be 25 per cent. Such minorities can and do carry elections. The oldsters are therefore a growing target for political aspirants, and here lies a sinister possibility.

It is an easy thing to sell to the impecunious aging and aged the idea of the "welfare state." Remember how we scoffed a generation ago at the foolish proposals of Dr. Townsend? Yet today far wilder schemes are being considered much more seriously. Unscrupulous politicians make promises with tongue in cheek, or hand out a few showy benefits, in order to gain power. And for such baubles, citizens have been willing to trade their priceless heritage of personal freedom. Two thousand years ago, the Roman politicians gained their point by the slogan "Bread and Circuses"; today that has been boiled down to a single word, "Security." The growing power of the group of aged voters is an important reason in the minds of many for enfranchizing the 18 year olds.

Now let us consider some of the medical aspects of gerontology: the growing field of *geriatrics*.

I shall not enumerate the various changes in structure and function of the several parts of the body that eventually constitute the full-blown picture of old age: they are well known to you all. But it deserves emphasis that the physician must be alert to their beginnings, and must know something of the usual time-table of their development. Here a knowledge of the family history is helpful in deciding whether a given change in the patient is premature, normal or delayed for his chronological age. Moreover, the

physician must distinguish between what is normal and what is pathologic: for example what is acceptable vascular fibrosis and what is the disease atherosclerosis.

This distinction between the normal and the abnormal is particularly difficult in the realm of the mind and psyche. Last to deteriorate in most persons, the mental activity long continues at a high level of efficiency. (That may be why no one thinks himself old, even though he is well aware of the physical limitations of an aging body.) Yet changes do come, notably a gradual failing of memory and a lessening ability to memorize. But forgetfulness can merge into a pathological loss of memory. An old patient of mine properly made notes to remind her of things she wished to ask me at the next visit, but the time came when she forgot what she had written right after turning the page and there repeated the same questions. And how often have you had to listen to the same story from a senile raconteur? The oldster is entitled to a soberer outlook on life, to conservatism, fatalism, lessened enthusiasms and frank pessimism. Now pessimism may be justified by the threat of poverty, unemployment or illness, but it can be magnified and distorted into extreme miserliness or a suicidal depression.

To evaluate properly the emotional reactions of our aged patients we must have a full knowledge of their circumstances and environment, their interests and activities. A potent cause of psychic change in the aged is loneliness. One of the greatest trials of aging is the loss of one's contemporaries. To make matters worse, the aged make less effort to be agreeable to those around them, and so may court neglect or even hostility in the household. To loneliness is now added discontent, and these smouldering emotions soon find expression in symptoms and complaints, that in turn mislead the unwary physician into erroneous diagnoses of organic disease.

What can the physician do about aging? If he knew more about the *mechanism of the processes*

of aging, he might well delay the ravages of time, and there is real promise that some day he will. Just as there are nutritional and endocrine factors that speed up or retard growth and maturation in early life, so there are undoubtedly factors that similarly influence decadence. Dietary deficiencies and the composition of the diet at any age, and especially at critical periods of development and growth, may determine the durability of various tissues. We know that the fluorine intake between 6 and 12 determines the resistance of the teeth to the formation of caries. The cholesterol-lipid ratio in the diet may well have something to do with the development of atherosclerosis. Bee larvae fed on honey alone grow to be worker bees that live a year, but the larva that is fed "royal jelly," a product of the throat of worker bees, becomes a queen bee that lives 5 years. There must be endocrine factors: witness the progeria of pituitary failure. The psychic traumata of early life have much to do with the mental problems of later years, and therefore attention to mental hygiene in youth should contribute much to better adjustment and therefore happiness in later years. But we know so little as yet about these things. We know least about the most important known factor in longevity: heredity. The best way to attain old age is still to pick the right ancestors.

In the absence of fuller knowledge of the determinants of longevity, our efforts are chiefly to help an individual to achieve his expected life span in health, vigor and happiness. This calls not only for the prevention and cure of disease, but for the prescription of a proper mode of life for the aging as well as the aged.

This prescription has four ingredients: *Work, Rest, Diversion, and Moderation in all things.*

Work is the best way to preserve strength and function. The wheel that doesn't turn, rusts. Unused faculties and skills weaken and atrophy. Therefore "work" means the regular performance of physical and mental exercise and the doing of as many things as the individual knows how to do, as often as it is feasible to do them.

Work, because it gives purpose to life, is the surest means to happiness. We have grown up only when we have come to realize that work in itself is keen enjoyment. The greatest good that I could wish for you, therefore, is that you may be permitted to work to the very last.

This by no means precludes retirement, which even when not forced upon us, we may nevertheless seek for excellent reasons. The important question then is not, when shall I retire? but what shall I do when I retire? That question is easily answered by the man with many interests and a wealth of spiritual resources. He can look forward to retirement as a welcome relief from chores assigned by others so that he can work twice as hard at things of his own choosing. But tragic is the fate of the man who knows only his work. We must acquire hobbies in youth if they are to serve us well in later years. They must be wisely selected and assiduously cultivated. Those hobbies are best which bring us into contact with others (as opposed to those pursued alone) and which are acceptable to us as a substitute for work.

Rest, the second ingredient of our prescription, is needed in increasing amounts to prevent undue fatigue. The after-lunch siesta should be a regular part of the daily program of the elderly. Vacations should be longer in the yearly aggregate and are best divided into two or more segments during the year.

Diversion is at all ages an important means to health and happiness, but especially so during the increased leisure time of advancing years. But today many people think of diversion as synonymous with amusement, and amusement in turn is mostly of the passive variety: movies, the radio, television and the newspaper, with emphasis on the comic strip. Yet there is far more satisfaction in making a little music than in just listening to it, or in disciplined study of a new subject and stimulating discussion of a timely topic than in idle reading. Even whittling on a stick is better than sitting idly by.

But to do such diverting things well, they must be learned when we are young and must be practiced through the years. To grow old happily we must accumulate not only money in the bank but resources of the mind on which we can draw in old age. Therefore our early training and our education even at high school age should include some preparation for old age. Above all, we should be taught how to continue to educate ourselves by self-imposed studies that should begin when formal education is over and should continue as long as we live. What are *you* studying now?

Moderation in all things applies not only to our work, rest and diversion, but such things as diet, habits and personal hygiene.

Diet must be moderate in quantity and properly balanced in kind. Obesity is the commonest disease in this country. It is also the greatest threat to longevity. Yet the aging are increasingly prone to it when one by one the other physical pleasures are denied or outlived and there remain only the joys of the table.

Deficient and poorly balanced diets are commoner among the aged than in any other group, sometimes because of poverty and poor dentition, but all too often because in their second childhood they indulge the whims and caprices that parental control interdicted in the first. It is often just too much trouble to prepare a proper meal or to go out to eat.

Alcohol is permissible, especially toward the end of the day, to those who enjoy it, but should not be prescribed for those who have never used it. Moderation is essential, but one is reminded of Perry Pepper's story of his ancestor, Benjamin Franklin, who as an old man, objecting to his physicians's ban on alcohol, reminded him that one sees more old drunkards than old doctors.

Smoking should be forbidden in the presence of serious cardiac disease, especially that of the coronaries, and in peripheral vascular insufficiency. Otherwise it may be allowed in moderation. The very old may have to have their tobacco rationed to keep it within bounds and

smoking in bed should never be allowed unless someone is present.

Sexual intercourse is largely limited by nature, but it may be necessary to advise moderation. One is reminded of the proverb that an old man's three worst enemies are a well-stocked wine cellar, a good cook, and a young wife.

Bathing once or twice a week is enough for the aged, lest the too frequent use of soap and water induce an eczema in a dry atrophic skin.

The state of the bowels must be watched in the aged, partly because of a tendency to constipation, partly because they are forgetful and may misrepresent the facts. A simple way of recording bowel movements in the bathroom is helpful. For constipation a mild laxative is to be preferred to the indignity of an enema.

Urination needs consideration in the elderly, especially in men with beginning prostatism, lest holding the urine too long induce an acute retention. Over 50 years ago, Dr. B. F. Hinkle, then in his eighties, gave me this good advice: "My boy, void whenever you get the chance, whether you need to or not. You never know when the next chance is coming."

Not only must we prescribe a mode of life for our oldsters, but we must advise those who are looking after them, especially their relatives. Here are some important rules to observe:

No house is big enough for two families. Therefore let the aged continue to live in their own home as long as they are able. When infirmity necessitates removal into the home of a relative, then the room so assigned should be furnished as far as possible with things from the old home: a favorite chair, desk, lamp or pictures as ties with the past. The privacy of its occupants must be respected: never enter without knocking.

Never separate a couple.

Encourage the aged to continue their old friendships and to make new ones. Urge them to go to church, club or lodge, and to observe anniversaries and significant occasions.

See that they have some spending money,

preferably given in payment of any services performed.

Let them be useful in the household. The young often thoughtlessly perform a task that they can finish in so much shorter time, but in so doing, they deprive the oldster of this important source of satisfaction.

Encourage them to be neat in dress and appearance. The surest tell-tale of senility is gravity on the vest.

Flatter them by asking their advice. Remember, too, that they won't tell you about your most obvious mistakes because they wish not to interfere in your affairs.

Above all, show them affection. They are happy in the knowledge that they are loved and wanted.

When the aged are ill, they are best cared for at home. They should be hospitalized only if circumstances demand it, or at their own request.

Intelligent nursing care during illness is of the greatest importance, and especially at night, when delirium is most likely to occur. Confusion is much more frequent at night, particularly when the patient has been recently moved to a new environment. He gets out of bed to go to the bathroom in the direction as remembered in his former domicile, only to fall down the back steps instead. In severe illness a night nurse is indispensable, and at all times there should be a small night light burning in the oldster's room. Our high hospital beds are a danger to any aged patient unless they are provided with side rails.

Bath room privileges are to be granted to the aged during illness whenever possible. The use of a commode at the bed side involves much less exertion and discomfort than does a bed pan.

It is out of the question to discuss individual disease problems within the scope of this presentation. But I would like to emphasize some important points in the general field of *diagnosis* and *treatment*.

History-taking in the aged is difficult because they are forgetful and they may also be unreliable. They will hide symptoms that might

reveal an illness that could cost them their job. They may feign illness, usually to gain sympathy, at times to inconvenience an unpopular member of the household. Nor is the family an unprejudiced source of information: they, too, may exaggerate, minimize or distort the facts as prompted by their own sentiments or to serve their own ends.

The physical examination and the laboratory must be relied upon all the more to reach a correct diagnosis. Here our sins are largely those of omission: failing to make a regular and complete physical examination is by far the commonest. We fail to count the pulse at the heart as well as at the wrist, or we fail to take the blood pressure in each arm, or we do not count the respirations. We do not look for lesions under dentures or under other prostheses or even garments. Particularly are we likely to skip the examination of rectum and genitalia in the aged.

In the field of *treatment*, we must remember that the aged eliminate some drugs more slowly and so may experience prolonged and cumulative effects. This calls for lower dosage, especially of opiates, hypnotics and even mild sedatives. The aged also need less digitalis, and so, with the highly potent preparations in use today, they may experience toxic effects if there is too rapid a loss of edema fluid by diuresis.

Some drugs have an altered reaction in the elderly. Hyoscyamine, scopolamine and belladonna at times produce delirium, and so should be used with caution and their effects noted at night.

The unfavorable side effects of ACTH and cortisone are more likely to occur in the aged than at any other time of life, because of existing vascular disease, mild diabetes, potential psychotic tendencies or chronic infection. Their use should therefore be cautious and not unduly prolonged.

Surgical treatment has won some of its finest triumphs in the aged, as, for example, in prostaticism and in fracture of the neck of the femur. This is due in part to better pre- and post-

operative care, better anesthesia, better surgical technique, early ambulation and the antibiotics. But some of the credit should go to a broadening experience in the surgery of the aged, and to the fact that there are more older surgeons. The older the surgeon, the more likely is he to appreciate the patient's viewpoint, and not just to think of him as an old wreck scarcely worth the effort of saving.

At this point I wish to emphasize an important prophylactic measure: the *prevention of accidents*. The commonest cause of death after heart disease and cancer is death by violence. Until 6 years ago this was primarily death by automobile; since then, fatal accidents in the home are at the head of the causes of death by violence, and those over 65 contribute over 80 per cent of the total. Accidents are preventable. What are *you* doing to prevent them? When you get home, check these potential dangers to your own life and limb: hard wood floors, carefully waxed once a week to make them slippery and then dotted with things quite properly called "throw" rugs; long lamp and telephone cords leading from the wall toward the center of the room that some one falls over as he gropes at night for a light switch; the piece of furniture shifted without warning and so to be encountered in the dark; loose toys anywhere; the stairs without handrails; the things left on the top or bottom step, to be carried up or down the next trip (only some one else trips first); bath tubs, showers and toilet seats without well-placed hand-grips to assist the elderly; the lack of night lights in country that must be traversed in the night; the unguarded unlighted stairway.

We all know how much help and comfort we get from glasses as we grow older. Most of us also replace lost teeth by proper dentures. But it is truly remarkable how often deafness goes uncorrected. Yet deafness is a very serious handicap and all too often responsible for loneliness and isolation, and even for serious accident. Therefore those with failing hearing should early be encouraged to seek the help of a hearing de-

vice. Now you don't advise them to get their glasses on the bargain counter of a department store: why let them get their hearing aids through a lay salesman? The otologist will select and fit the proper device, instruct the patient in its use, and let him know how to learn lip reading.

My final advice is on the subject of *keeping proper records* of your aging patients. The law recognizes that a child is unable to enter into a contract before reaching the age of legal responsibility, but it assumes that the oldster remains competent until proved otherwise. Yet many persons live long enough to become incompetent. The aged must depend more and more upon others to manage their affairs, and so are likely to favor those on whom they depend, when they come to bequeath their possessions. They may fall victims to designing sycophants or may properly decide to do more for thoughtful strangers than for their neglectful relatives. The physician's observations here assume great medico-legal importance: he has studied the patient over the years, sees the beginnings and degree of mental decay, knows the status of family relationships, and so is sure to be called upon if a will is contested. Therefore he should be observant and keep *written dated*

records. He had also best preserve his own status of neutrality by refusing to be a signing witness to a patient's will.

There is so much more that could and need be said on the many phases of our subject. But, I must content myself with just one more thought in closing. The most *useful therapeutic measure* in all aspects of treatment of the ills of the aged is *sympathy*. They don't get too much of it at best. A kindly approach, a patient ear, a word of understanding of the oldster's problems, a cheerful word of reassurance and encouragement: these will potentiate the simplest remedies into miracle drugs; their lack will result in failure, because of the consequent absence of the greatest factor for the oldster's survival: the *will to live*.

Temple University Hospital
3401 North Broad Street
Philadelphia 40, Pennsylvania

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2. KERN, R. A.: Chapter on Care of the Aged in Musser & Wohl, Text Book on Internal Medicine, 5th Ed.; Philadelphia: Lea & Febiger, 1951.
3. KERN, R. A.: Problems of an Aging Population, G. P.: **4**, 47, 1951.

THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC.

Office of the Secretary—Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio

Applications for certification (American Board of Obstetrics and Gynecology) for the 1955 Part I Examinations are now being accepted. Candidates are urged to make such application sometime in July or August.

All candidates for admission to the Examinations are required to submit with their application, a plain typewritten list of all patients admitted to the hospitals where they practice, for the year preceding their application or the year prior to their request for reopening of their application, with the diagnosis, pathological diagnosis, nature of treatment, and end result.

Application for examination or re-examination, as well as requests for resubmission of case abstracts, must be made to the Secretary prior to October 1, 1954.

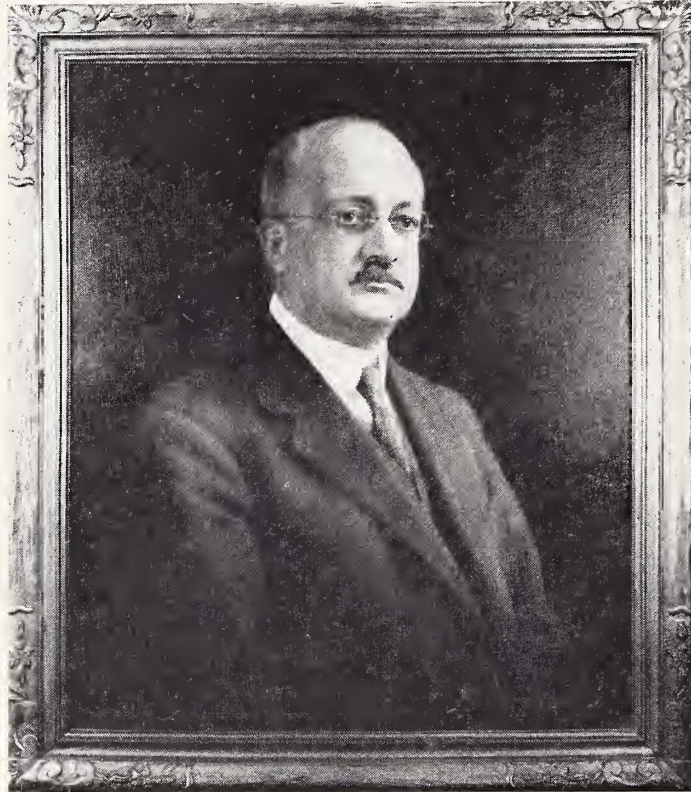
Under a change of requirements for the Part I Examination, candidates must submit 20 case abstracts rather than 25 as formerly. Five of these may be from one's residency service.

PRESENTATION OF PORTRAIT OF DR. JOHN RUHRÄH*

FRED B. SMITH, M.D.

DR. KNEISLEY: I should now like to call on Dr. Fred B. Smith who has a duty to perform.

DR. FRED B. SMITH: Dr. White, Dr. Kneisley, Dr. Andrus, Members of the Medical and Chirurgical Faculty, and Guests. Given a man endowed with high intelligence to begin with, long experience and hard study, and the result is confidence.



DR. JOHN RUHRÄH

Dr. John Ruhräh had it to perfection and the laity, although they did not know whence it arose, recognized it and to people who are bewildered and frightened, this confidence was as a draught of water to a traveler in the desert.

He was more than a member of the medical profession; more than a member of the Baltimore School Board; more than a distinguished, if adopted Marylander. He was a citizen of the world, a rich and vivid personality whose slightest contact was a challenge to the intelligence.

Dr. Ruhräh was born September 26, 1872, in Chillicothe, Ohio. After his high school education he received his medical degree from the College of Physicians and Surgeons, Baltimore, 1894. He was Assistant Resident Physician at Mercy Hospital from 1894 to 1895, and Resident Physician 1895 to 1897. He was physician in charge of Pasteur De-

* Presented at the One Hundred and Fifty-sixth Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, on Tuesday evening April 27, 1954, in Osler Hall, 1211 Cathedral Street, Baltimore 1, Maryland.

partment of the College of Physicians and Surgeons in 1897. He took postgraduate courses at The Johns Hopkins Medical School; at the l'Institute of Paris, 1897, and at the Universities and hospitals in Vienna, Paris and Berlin 1900 and 1901. From 1898 to 1900 he was Quarantine Physician at the Port of Baltimore. In 1916 he was the first appointee to the Chair of Diseases of Children at the University of Maryland Medical School, a position he held until the year 1927. He was also visiting physician to the Mercy Hospital, Consulting Physician to the Church Home Infirmary, and Visiting Physician to the Hospital for the Women of Maryland. He worked diligently at the Nursery and Child's Hospital on Schroeder Street for years. He died in Baltimore at the Mercy Hospital, March 10, 1935.

Dr. Ruhräh was elected president of the American Pediatric Society, 1912, president of the Medical and Chirurgical Faculty of Maryland 1919; president of the Medical Library Association 1927; president of the Research Society 1932; president of the Osler Historical Society 1933; president of the American Academy of Pediatrics 1934. He was appointed a Member of the Board of Education, Baltimore City and in 1932 he was selected by the Baltimore City Medical Society to prepare a history of the Medical Profession in Maryland for the last quarter century, a task which he was well qualified to perform. He entered private practice in 1901. He never married. He was a facile writer, the author of several books. He contributed articles on Pediatric subjects to most of the modern American encyclopedias and systems of medicine as Osler's *Modern Medicine*; Nelson's *Living Medicine*; Tice's *Practice of Medicine*; Abt's *Pediatrics* and Brennaman's *Pediatrics*. One of his impelling interests was his love of books.

In the words of Dr. Isaac Abt, of Chicago, "Ruhräh had a matchless personality and a great facility for establishing enduring friendships. He was extremely tolerant. He forgave shortcomings and appreciated even the minor virtues of his fellowmen. He mingled well with all classes of people. The lowly and untutored did not repel him and he met the intelligentsia gracefully and with exceptional poise. He was always reminded of a choice tale from a rare book or a forgotten author. His artistic traits were not confined only to art and literature. He was also a devotee of fine music. He made the Annual Pilgrimage to Bethlehem, Pennsylvania, for the Bach Music Festival."

Dr. Ruhräh lived a full life. He had an artistic nature which craved the cultural things of life. These he found it possible to provide for himself.

After his severe affliction in 1930, by undaunted courage and indomitable will, he was happily able to resume his work and his recreations.

Dr. Ruhräh leaves a rich heritage of devoted service dedicated to medicine and humanity. "A man beloved, a man elect of men." Everyone here knows his interest in the Faculty as evidenced by his indefatigable work to procure the new building in which he was instrumental in the organization of and its development. His interest in the Library was evidenced by his leaving his books which he so loved and his residuary estate.

It was an important part of Dr. Ruhräh's service to the city that he strengthened the belief that men of his profession may be and ought to be in Mr. Burk's excellent phrase: "Its guidepost and landmarks in the State."

DR. KNEISLEY: On behalf of the Faculty, we wish to receive this portrait of Dr. Ruhräh, with sincere thanks and appreciation and I am sure that when we place it in the hand of our esteemed and very devoted member, Dr. Chatard, who is our Curator, it will have his very considerate care. Thank you very much.

*11 East Chase Street
Baltimore 2, Maryland*

Business Sessions

SEMIANNUAL MEETING

Tuesday, October 6, 1953

House of Delegates

Auditorium, Clinical Center Building

National Institutes of Health, Bethesda, Maryland

The 207th meeting of the House of Delegates was called to order by the President, Dr. Maurice C. Pincoffs, at 9:30 a.m. in the Auditorium of the Clinical Center Building of the National Institutes of Health, Bethesda, Montgomery County, Maryland, on Tuesday, October 6, 1953.

The following members registered: Doctors Conrad Acton, David H. Andrew, E. Cowles Andrus, Cecil H. Bagley, O. H. Binkley, J. W. Bird, McKendree Boyer, Helen Bowie, Otto C. Brantigan, Howard M. Bubert, R. V. Campbell, Ferdinand E. Chatard, IV, J. Albert Chatard, Alan M. Chesney, Thomas A. Christensen, Bernard J. Cohen, Melvin B. Davis, Richard C. Dodson, Monte Edwards, Wolcott Etienne, Whitmer B. Firor, Palmer H. Futcher, C. R. Goldsborough, Wilson Grubb, William Hanks, John M. Haws, James G. Howell, Emmett L. Jones, James R. Karns, Harry F. Klinefelter, Jr., B. B. Kneisley, Louis Krause, William B. Long, Edward F. Lewison, W. Kenneth Mansfield, James T. Marsh, Waldo B. Moyers, W. O. McLane, Claude W. Mitchell, Zachariah R. Morgan, G. W. Murgatroyd, Jr., Edmund R. Novak, Thomas R. O'Rourke, John W. Parsons, A. Austin Pearre, Peter P. Rodman, N. E. Sartorius, Jr., E. C. M. Schmidt, T. B. Whaley, A. F. Whitsitt, H. E. Wilgis, Palmer F. C. Williams, Arthur O. Woody, and George H. Yeager.

ON MOTION OF DR. MONTE EDWARDS, SECONDED BY DR. JAMES T. MARSH, THE MINUTES WERE ACCEPTED AS PRINTED AND DISTRIBUTED.

Dr. Pincoffs brought to the attention of the House of Delegates that a subcommittee has been appointed to consider the problem of raising dues, and that previous action of the House of Delegates empowered this Committee to make appropriate recommendations to the Committee on Constitution and By-Laws for presentation to the House of Delegates. The appointed Committee was composed of Doctors W. O. McLane, Chairman, Harry F. Klinefelter, Jr., W. Kenneth Mansfield, Claude W. Mitchell and N. E. Sartorius, Jr. It considered the problem of dues in the Society and the recommendations being made by the Committee on Constitution and By-Laws are based on the report of the Subcommittee to Investigate Dues. Dr. Pincoffs further pointed out that in an effort to give broader representation of the State Society in matters of finance that the following Committee, which is to be known as

the Budget Committee has been appointed by Dr. C. Reid Edwards, the Chairman of the Council. The members of this Committee are as follows: Doctors Wetherbee Fort, *Chairman*, Robert Van Lieu Campbell, Richard C. Dodson, Robert C. Kimberly and Norman E. Sartorius, Jr.

Dr. Pearre reported for the Committee on Constitution and By-Laws. (See page 408.) He presented proposed amendments as follows:

CHAPTER II—Dues and Assessments

Section 1. *Active Members.* Funds shall AMEND \$20.00
TO READ \$30.00

be raised by per capita dues to be paid by every member of the component societies. The amount of the dues shall be \$20.00 per capita per annum for active members in the County Societies and \$35.00 for active members of the Baltimore City Medical Society, with the following exceptions:

AMEND \$35.00
TO READ \$50.00

a. In the County Medical Societies the following rates shall prevail: for the first year in private practice the dues shall be \$10.00 per annum; for the second year, \$15.00; and the third year and thereafter, \$20.00.

AMEND \$20.00
TO READ \$30.00

b. In the Baltimore City Medical Society the following rate shall prevail: for the first year in private practice the dues shall be \$15.00 per capita per annum; for the second year, \$25.00; and the third year and thereafter, \$35.00.

AMEND \$35.00
TO READ \$50.00

c. As long as a physician is on the resident staff of a hospital or fellowship and not in private practice, his dues for membership in either the Baltimore City Medical Society or the County Medical Societies shall be \$2.50.

ON MOTION OF DR. JAMES T. MARSH, SECONDED BY DR. CLAUDE W. MITCHELL, THESE AMENDMENTS WERE APPROVED.

Section d. as follows was read to the House of Delegates:

d. The dues of a licensed physician in Maryland who holds an academic position on a full time salary basis, other than as a fellow or house officer, shall be \$15.00 per annum during the first five years of his academic position.

THIS SECTION
TO BE
DELETED

It was proposed by the Committee on Constitution and By-Laws that this Section be deleted.

Dr. Pincoffs pointed out that at present Section "d" permits younger men holding academic positions the status of Associate Membership. However, they can not vote, nor hold office, nor have Physicians' Defense, and are therefore, unable to be an integral part of the Faculty. It was his opinion that every effort should be made to have the continued active participation by these younger men. The Chairman asked for a motion of approval of the recommendations of the Committee. No motion ensued and the Chair ruled that this indicated the disapproval of the delegates for deletion of Section "d". Dr. E. Cowles Andrus then moved that prior to the next Annual Meeting, a survey be made of the potential members of the Faculty affected by the deletion of this Section of the By-Laws and that the matter again be brought before the House of Delegates. Seconded by Dr. Thomas A. Christensen and carried. (See page 408, 414, 463.)

Dr. Pearre then read the last paragraph of Section 1 of the proposed amendment which follows:

Such per capita assessment is to be included in annual dues of the individual member as paid to his component society; and any member paying dues in each current year prior to ten days before the Annual Meeting is to be considered an active member. However, it is herein exacted that only active members, whose dues have been paid in advance, prior to January thirty-first, of each current year, will be eligible for the provision of Physicians' Defense.

AMEND
"assessment is"
TO READ
"DUES ARE"

ON MOTION OF DR. JOHN W. PARSONS, SECONDED BY DR. JAMES T. MARSH, THIS RECOMMENDATION WAS APPROVED.

Mr. Kirkman reported on the results of the \$10.00 assessment approved by action of the House of Delegates in April, 1953. (See pages 408-409.) He brought out the fact that there is no penalty according to the Constitution and By-Laws of the Faculty for non-payment of an assessment. Considerable discussion followed in which it was pointed out that there might be some misunderstanding on the part of the members concerning the payment of the assessment, and it was suggested that further bills be sent out. Dr. Yeager pointed out that authority to do this has been granted by the Council and appropriate billing would ensue.

Dr. Chatard expressed his thanks to the House of Delegates for their efforts in stabilizing the financial condition of the Faculty and extended his appreciation to Mr. Kirkman. He also commended the appointment of a Budget Committee.

Dr. Chatard also expressed his appreciation for the inestimable work the Journal is accomplishing.

At the request of the President, Dr. Yeager reported on the appointment of the Committee on Veterans' Medical Care. The American Medical Association has requested that each State Society have such a Committee in order to evaluate and promulgate a program opposing medical care given by the Veterans' Administration to veterans with non-service connected disabilities. This Committee comprises Doctors Ralph G. Hills, Chairman, Ernest I. Cornbrooks, Jr., Raymond M. Curtis, R. Walter Graham, Jr., and Harry C. Hull. Approval of the House of the action of the Council in appointing this Committee was requested. On motion of Dr. Thomas A. Christensen, seconded by Dr. Robert V. L. Campbell, the appointment of the Committee by Council was approved.

Dr. Ralph G. Hills, Chairman of the Committee on Veterans' Medical Care, then reported on the activities of the Committee. (See page 409.) He gave the background of the progress made in veterans' care since its inception in the late 1800's to the present time. He stated that at the present time 80-85% of the cases now treated in Veterans' Hospitals are non-service connected. Additional beds have been requested for veterans' care although at the present time more than twenty thousand beds are available. It is the plan of this Committee to obtain as much factual information as possible from the Veterans' Hospitals in Maryland and to disseminate such information to the medical profession.

Dr. Hills requested permission of the House of Delegates for the members of his Committee to study the Veterans' Hospitals in Maryland in an attempt to obtain factual data regarding the percentage of service and non-service connected disabilities. Dr. Harry F. Klinefelter, Jr., moved that such approval be given, seconded by Dr. Waldo B. Moyers. Dr. R. Walter Graham, Jr., then amplified on the conditions in the Veterans' Hospitals today, giving many of the details which came out in the meeting of the House of Delegates of the A.M.A. in New York in June, 1953. Dr. John W. Parsons stated that he had attended the A.M.A. meeting, and pointed out to the House of Delegates that the American Legion is highly favorable towards all veterans being given medical care regardless of the connection of the disability to actual service. This organization is said to have a powerful lobby and is bringing this view before the next Congress. Dr. Parsons further stated that he thought any attempt to investigate hospital admissions by any outside group, such as our Society, would be futile, and that such information could only be obtained through an Act of Congress. He felt that this body should approve the action of the House of Delegates of the A.M.A. and requested that the motion of Dr. Harry F. Klinefelter, Jr., be withdrawn. Dr. Klinefelter withdrew his motion with approval of Dr. Moyers, who had seconded it.

DR. PARSONS THEN MOVED THAT THE HOUSE OF DELEGATES OF THE MEDICAL AND CHIRURGICAL FACULTY GO ON RECORD AS APPROVING THE ACTIONS OF THE HOUSE OF DELEGATES OF THE A.M.A. IN NEW YORK IN JUNE, 1953, REGARDING CARE OF VETERANS, AND THAT NOTICE OF THIS APPROVAL BE FORWARDED TO THE MARYLAND MEMBERS OF THE CONGRESS. DR. MOYERS PROPOSED AN AMENDMENT TO HIS MOTION THAT SIMILAR ACTION BE REQUESTED FROM

EACH COMPONENT SOCIETY. THE MOTION AS AMENDED WAS CARRIED.

Dr. Yeager informed the House of Delegates of the proposed Crash Injury Research of Cornell University Medical College which had been approved by Council, and for which ratification was necessary by the House of Delegates. He stated that it was hoped that such a study would prove of value in determining the relation of automobile design to accident injuries, and thereby improve automobile design. The study will cover an area of the Washington Boulevard lying in three counties—Prince George's, Anne Arundel, and Baltimore Counties. State-wide cooperation from the State Medical Society will be necessary for the study to be effective, and will require the filling out of forms by physicians in the area under study. IT WAS MOVED BY DR. WILSON GRUBB, SECONDED BY DR. ALAN M. CHESNEY, THAT THE ACTION OF THE COUNCIL IN APPROVING THE CRASH INJURY STUDY BE RATIFIED. THE MOTION WAS CARRIED.

Dr. Robert V. L. Campbell reported for the Resolutions Committee. (See page 409.)

Dr. Campbell read the following:

The following paragraphs are quoted from the report of the Committee to Study Legislative and Professional Standards and Staff Relations of Hospitals, as they contain recommendations which were referred to the Resolutions Committee by the House of Delegates at its meeting in April, 1953: "This Committee now feels that this provision should be replaced in the law since we believe the professional staff of any hospital is one of the most important elements of that hospital's satisfactory performance. Although some may have apprehension that this being administered by the State Department of Health might create an undesirable setting of control by a state agency of professional activities in a hospital, we do not believe that this will follow. On the contrary, the Maryland State Department of Health, through the Board of Health, has adequate representation of the practicing medical profession of the State. Furthermore, we recommend that in the administration of the hospital licensure law, with the added feature of setting standards for professional staff, the State Board of Health establish an Advisory Committee from the Medical and Chirurgical Faculty of the State of Maryland. If this recommendation is followed out, the Medical Faculty would have a direct access to advise the State Board of Health on hospital licensure. The Committee further recommends to the House of Delegates that these members from the Medical and Chirurgical Faculty be a combination of appointive and elective members."

The resolutions committee felt that it should not approve or disapprove this resolution because it involved basic policy. It, therefore, recommends that this resolution be referred to the council.

Dr. Emmett L. Jones, of Allegany-Garrett County, moved that the House of Delegates does not approve of the original recommendations in the report regarding the State Department of Health in relation to hospitals and professional qualifications. There was no second to the motion, and therefore it died on the floor. DR. THOMAS A. CHRISTENSEN THEN MOVED THE RECOMMENDATION OF THE RESOLUTIONS COM-

MITTEE BE ACCEPTED AND THAT THE MATTER BE REFERRED TO THE COUNCIL. SECONDED BY DR. JAMES T. MARSH, AND CARRIED.

Dr. Campbell stated that the following is quoted from a letter from Dr. Albert E. Goldstein regarding the advisability of assessing each member for the Building Fund:

- "1. It is very essential that we must have additions and conversions.
2. We have collected in the neighborhood of \$75,000 by voluntary contributions.
3. That the Committee does not object to continue to solicit men who have not been solicited, but that a more equitable manner would be to collect the entire amount by getting every member of the Medical Society to contribute something.
4. It is the suggestion of the Committee to assess active members of the Baltimore City Medical Society \$150.00 and all County members \$100.00. The above to be designated for individuals who are out 5 or more years in practice. Those under 5 years, some amicable arrangement can be made for an assessment for these men.
5. The period of time allotted for this assessment can be determined by the individual himself—over a period of ten years, if necessary, but it may be paid immediately, or next year, or whenever desired.
6. It is absolutely essential to obtain this money, as the renovation and additions must be made or our valuable Faculty Building will be done away with."

The resolutions committee recommends that this discussion be deferred until 1954.

DR. J. ALBERT CHATARD MOVED THAT THE RECOMMENDATION OF THE RESOLUTIONS COMMITTEE BE APPROVED. SECONDED BY DR. JAMES T. MARSH AND CARRIED.

Dr. Campbell said that Dr. Julian S. Lane submitted recommendations regarding accident cases under the State Industrial Accident Commission being given free choice of physicians. The following is quoted from Dr. Lane's letter:

"Some time ago, I spoke to you concerning the question of free choice of physicians by industrial accident cases. I have had a communication relative to the question from the Industrial Accident Commission a few months ago, stating that since the employer and Insurance Carrier pay the costs, they should have the right to designate a physician. The patient may change to another physician if he feels that treatment is inadequate, only, however, after first going to the designated physician; but then the burden of proof that treatment was inadequate is on the patient. Apparently this is the present policy of the Commission. I need hardly say that I am writing because I am heartily opposed to this policy.

"If the employers and carriers paid these costs out of the goodness of their hearts and an abiding love for humanity, I would recognize the validity of the first part of this policy. But the insurance is carried because it is ordered by law for the protection of the injured.

"It has been my observation that patients will not take upon themselves the burden of proof of inadequate treatment, preferring to disclaim industrial liability even after visiting a designated physician in cases of minor injury, and

very anxiously awaiting the paternalistic permission to change physicians in major cases. There is no doubt that the present policy of the Commission produces a great percentage of highly dissatisfied patients. To say the very least, the policy of the Commission disturbs the very basis of patient-physician relationship of private practice.

"It seems to be a most peculiar breach of conviction that in the midst of our opposition to socialized medicine, we should inflict such a contradictory regulation on the industrial public, for there is no doubt that this is socialization. There are examples of progressive states whose lead we have followed in providing voluntary health insurance that do provide free choice of physicians in industrial accident cases; nor is there any doubt that the same insurance companies operating in Maryland pursue their business as eagerly in states like New York for example.

"Therefore, will you request the Delegates to vote on the question of forwarding a recommendation to the Industrial Accident Commission that industrial accident cases be given a free choice of physicians. That the right of free choice of physicians be adequately posted in all areas of industrial activity so that the information shall be made available to all employees. This recommendation shall not be meant in any way to affect the employment on salary by industrial plants of physicians to practice their industrial medicine in offices on the plant premises provided again that the employees are aware of their right to free choice."

THE RESOLUTIONS COMMITTEE SUBMITS AN UNFAVORABLE REPORT. THE COMMITTEE FEELS THAT THE INSURER WHO PAYS THE BILL FOR THE MEDICAL CARE HAS THE RIGHT TO DESIGNATE PHYSICIANS: THIS FACT HAS BEEN ESTABLISHED BY LAW AND THE MEDICAL AND CHIRURGICAL FACULTY HAS NO AUTHORITY TO RULE OTHERWISE.

DR. WILLIAM B. LONG MOVED THAT THE HOUSE OF DELEGATES ACCEPT THE RECOMMENDATION OF THE RESOLUTIONS COMMITTEE OF AN UNFAVORABLE REPORT. THIS WAS SECONDED BY DR. JAMES R. KARNS AND CARRIED.

Dr. Campbell reported that Dr. Wilson Grubb had presented the following resolution:

"Whereas, previous experience has shown that Ocean City, Maryland, has proven to be most successful as a meeting place for the Semiannual Meeting of the Medical and Chirurgical Faculty; and,

"Whereas, repeatedly holding such meetings will create a burden on the local Component Society; be it

"Resolved, That all future Semiannual Meetings of the Medical and Chirurgical Faculty of the State of Maryland be held in Ocean City, Maryland; and be it further

"Resolved, That the responsibility for the arrangements and expenses involved shall not necessarily be that of any Component Society, but will be primarily that of the Committee on Scientific Work and Arrangements of the Medical and Chirurgical Faculty."

THE RESOLUTIONS COMMITTEE SUBMITS A FAVORABLE REPORT PROVIDING THAT IN PARAGRAPH 3 AFTER THE WORDS "OCEAN

CITY, MARYLAND," BE ADDED "UNLESS INVITED BY ANOTHER COUNTY."

DR. THOMAS A. CHRISTENSEN MOVED THAT THE REPORT OF THE RESOLUTIONS COMMITTEE BE ACCEPTED. SECONDED BY DR. JAMES T. MARSH AND CARRIED.

Dr. Campbell brought to the attention of the House of Delegates the following:

As a result of action taken at the April, 1953, meeting of the House of Delegates on a resolution submitted by Dr. Klinefelter, Dr. Conrad Acton, with the approval of Dr. Klinefelter, submitted the following resolution:

"Whereas, the Maryland Chapter of the National Arthritis and Rheumatism Foundation has conducted clinics in 17 of the 23 Counties in the State of Maryland since March, 1952, and

"Whereas, a generous and unstinted service has been rendered to patients and their physicians in these Clinics, therefore,

"Be it resolved, that the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland hereby commends the Maryland Chapter of the National Arthritis and Rheumatism Foundation for its generous and unstinted service to the people of this State."

THE RESOLUTIONS COMMITTEE, ALTHOUGH IT FEELS THAT THE ABOVE ORGANIZATION HAS PERFORMED VALUABLE SERVICES IN OUR STATE, SUBMITS AN UNFAVORABLE REPORT. TO SET A PRECEDENT BY COMMENDING THIS ORGANIZATION WOULD MEAN THAT THE MANY OTHER SIMILAR ORGANIZATIONS THROUGHOUT THE STATE WHO HAVE RENDERED VALUABLE SERVICES SHOULD AND WOULD APPLY FOR SIMILAR COMMENDATION.

DR. HOWARD M. BUBERT MOVED THAT THE RESOLUTIONS COMMITTEE REPORT BE ACCEPTED. SECONDED BY DR. WILSON GRUBB AND CARRIED.

The following and final report for the Resolutions Committee was presented by Dr. Campbell:

"As a result of the report of the Committee for the Better Distribution of Doctors Throughout the State, the Chairman was notified by the Secretary of the Medical and Chirurgical Faculty that if he wished additional action taken regarding his report in April 1953 to the House of Delegates, that Dr. Voshell, the Chairman, and his Committee submit recommendations to the Resolutions Committee.

THE RESOLUTIONS COMMITTEE SUBMITS AN UNFAVORABLE REPORT. NO ACTION HAS BEEN TAKEN BY THE COMMITTEE INVOLVED SINCE THIS MATTER WAS PRESENTED IN ITS PRESENT FORM AT THE LAST MEETING OF THE HOUSE OF DELEGATES.

DR. THOMAS A. CHRISTENSEN MOVED THAT THE RECOMMENDATION OF THE RESOLUTIONS COMMITTEE BE APPROVED, SECONDED BY DR. O. H. BINKLEY AND CARRIED.

There being no new business, the House of Delegates adjourned at 10:55 a.m.

Respectfully submitted,

GEORGE H. YEAGER, M.D., Secretary

EVERETT S. DIGGS, M.D., Assistant Secretary

REPORTS PRESENTED AT SEMIANNUAL MEETING

Committee on Constitution and By-Laws

Mr. President and Members of the House of Delegates:

It will be recalled that at the meeting of the House of Delegates on Tuesday, April 28th of this year at our Annual Meeting in Baltimore, a serious financial situation of the Medical and Chirurgical Faculty was pointed out and the need to obtain an increased income to carry on the important work of the Faculty was emphasized. This Body authorized our President to appoint "a committee of five members to be made up of County and City Delegates to confer with the Committee on Constitution and By-Laws in the study of this problem and to present a realistic solution not less than sixty (60) days before this Semiannual Meeting in 1953."

Dr. Pincoffs, as you know, appointed Dr. W. Oliver McLane, Jr., Chairman of this Special Committee and Dr. Claude W. Mitchell, Dr. Norman E. Sartorius, Jr., Dr. W. Kenneth Mansfield and Dr. Harry F. Klinefelter, Jr. members. On June 9th the Committee on Constitution and By-Laws of the Faculty met with this Special Committee "to render a solution to the question of raising dues for the active members of the State Society."

On July 13th the recommendations of this Committee, and of the Committee on Constitution and By-Laws, were sent to the Component Societies and to the individual delegates. As you all know, our By-Laws may be amended at any Semiannual meeting by a majority vote of all the delegates present at that session, providing the amendment has been sent officially to all the delegates at least thirty (30) days prior to the Semiannual Meeting.

Accordingly, in compliance with a request from the Special Committee appointed by mandate of the House of Delegates by Dr. Pincoffs, your Committee on Constitution and By-Laws submits the following amendments to Chapter II of the By-Laws regarding dues and assessments as pertaining to active members.

Report of the Committee on Constitution and By-Laws of the Medical and Chirurgical Faculty to the House of Delegates, Semiannual Meeting, October 6, 1953

Amendments to By-Laws*

CHAPTER II—Dues and Assessments. (See page 404.)	
Section 1. <i>Active Members.</i> Funds shall be raised by per capita dues to be paid by every member of the component societies. The amount of the dues shall be \$20.00 per capita per annum for active members in the County Societies and \$35.00 for active members of the Baltimore City Medical Society, with the following exceptions:	AMEND \$20.00
	TO READ \$30.00
	AMEND \$35.00
	TO READ \$50.00
a. In the County Medical Societies	
AMEND \$20.00	

* Amendments appear in capital letters in the margin.

the following rates shall prevail: for the first year in private practice the dues shall be \$10.00 per annum; for the second year, \$15.00; and the third year and thereafter, \$20.00.

b. In the Baltimore City Medical Society the following rate shall prevail: for the first year in private practice the dues shall be \$15.00 per capita per annum; for the second year, \$25.00; and the third year and thereafter, \$35.00.

c. As long as a physician is on the resident staff of a hospital or fellowship and not in private practice, his dues for membership in either the Baltimore City Medical Society or the County Medical Societies shall be \$2.50.

d. The dues of a licensed physician in Maryland who holds an academic position on a full time salary basis, other than as a fellow or house officer, shall be \$15.00 per annum during the first five years of his academic position. (See page 405.)

Such per capita assessment is to be included in annual dues of the individual member as paid to his component society; and any member paying dues in each current year prior to ten days before the Annual Meeting is to be considered an active member. However, it is herein exacted that only active members, whose dues have been paid in advance, prior to January thirty-first, of each current year, will be eligible for the provision of Physicians' Defense. (See page 405.)

It is to be hoped that our membership has found time to read Faculty Facts and the Financial Statement of the Faculty in the June and August issues of The Journal. It is essential that the Faculty's income be increased.

These amendments are respectfully submitted by
A. AUSTIN PEARRE, M.D., *Chairman*
E. COWLES ANDRUS, M.D.
DONALD HOOKER, M.D.
W. HOUSTON TOULSON, M.D.

Report on Payment of Assessment

Mr. President and Members of the House of Delegates:

At the Annual Meeting in April, 1953, the House of Delegates imposed an assessment of \$10.00 on every full dues paying member of the Faculty to relieve the financial astringency for the fiscal year 1953. The assessment was due and payable on July 1, 1953.

TO READ \$30.00
AMEND \$35.00
TO READ \$50.00
THIS SECTION TO BE DELETED
AMEND "assessment is" TO READ "DUES ARE"

In accordance with this mandate, bills were forwarded to the members subject to the assessment in June, 1953, together with a covering letter, signed by the Executive Committee of the Council, explaining the need for increased revenue.

To this date, October 6, 1953, collections are as follows:

Subject to Assessment

Baltimore City Members.....	1069
County Members.....	820

	1889

Paid

Baltimore City Members, 824 or 77%
County Members, 606 or 73%

Baltimore City Members paid.....	824
County Members paid.....	606

Total paid.. 1430 or 75%

(See page 405)

Respectfully submitted,
WALTER N. KIRKMAN, *Director*

Report of the Committee on Veterans' Medical Care

Mr. President and Members of the House of Delegates :

The Committee on Veterans' Medical Care, of which I am the Chairman, has recently been exploring particularly the medical care of non-service-connected disabilities of veterans. We might start with reviewing historically this service to veterans.

In 1917 the Congress passed the first law providing for the care of veterans who were disabled as a result of injury or sickness while on active duty. In 1923 because of the inadequacy of tuberculosis and neuropsychiatric facilities, non-service-connected disabilities were permitted to use Government facilities. In 1926 another Bill was passed permitting any non-service-connected disability to use veterans' facilities providing beds were available. In 1933, the 1926 law was repealed and a Pauper's Oath was inserted for the use of non-service-connected disabilities. At the present time there are about one hundred sixteen thousand (116,000) veterans' beds, and because of the increasing non-service-connected veterans using these facilities there is a shortage of beds. Recently before a Congressional Investigating Committee it was found that 350 cases had incomes of between \$4,000 and \$50,000 per year. It has also been shown that approximately 80% of the patients in veterans hospitals are non-service-connected. Actually twenty-one million (21,000,000) veterans under the

present law. providing the Pauper's Oath is not honored, are eligible for the veterans' care. To go one step further, if the wives of these veterans were added, forty-two million (42,000-000) people would be eligible for veterans' care. Then carrying this still one step further by adding 2½ children per couple, we would have one hundred million (100,000,000) people eligible for free medical care.

After all this is nothing but socialized medicine sneaking in through the back door. If the American people want socialized medicine they should be permitted to vote on the subject and not have it thrust upon them without their knowledge. Lenin is supposed to have once said that socialized medicine is the key stone in the arch of socialism. It is true that the doctors are among the most individualistic group in the Country, and each doctor has many hundreds of patients who will listen seriously to his views.

I believe that most doctors are against this creeping socialism and your Committee will attempt to obtain all the facts and transmit them to the medical profession of the State.

Your Committee would like instructions as to whether you would sanction in principle its investigating the three veterans hospitals in this State as to the percentage of service and non-service-connected medical care.

Your Committee hopes that this House of Delegates will sanction the action of the House of Delegates of the American Medical Association at its meeting in New York in June 1953 as it expects to work in cooperation with the A.M.A. Committee on Federal Medical Services of the Council on Medical Service.

Respectfully submitted,
RALPH G. HILLS, M.D., *Chairman*
ERNEST I. CORNBROOKS, JR., M.D.
RAYMOND M. CURTIS, M.D.
R. WALTER GRAHAM, JR., M.D.
HARRY C. HULL, M.D.

Report of the Resolutions Committee

Mr. President and Members of the House of Delegates :

This Committee has reviewed the resolutions, etc. referred to it since the last meeting of the House of Delegates in April 1953, and recommends the action as given in our report. See House of Delegate meeting October 6, 1953, as entire report is quoted in the minutes, pages 404-407.

Respectfully submitted,
ROBERT V. L. CAMPBELL, M.D., *Chairman Pro Tem*
WILLIAM D. NOBLE, M.D., *Chairman*
CHARLES R. AUSTRIAN, M.D.
F. FORD LOKER, M.D.
M. C. PORTERFIELD, M.D.

For complete Semiannual Meeting program see pages 439-444 and also September 1954 Maryland State Medical Journal for Addresses by Dr. J. W. Bird and Dr. Leonard A. Scheele, Surgeon General

* * *

ANNUAL MEETING

HOUSE OF DELEGATES

*Deutsches Haus, Second Floor Auditorium, 1212 Cathedral Street,
Baltimore*

SPECIAL SESSION¹

Monday, April 26, 1954, 10:00 a.m.

The 208th Special Session meeting of the House of Delegates was called to order by the President, Dr. Bender B. Kneisley, presiding, at 10:00 a.m., in the Deutsches Haus, 1212 Cathedral Street, Baltimore, Maryland, on Monday, April 26, 1954.

The following members registered: Doctors Conrad Acton, Warde B. Allan, E. Cowles Andrus, Philibert Artigiani, Charles R. Austrian, John W. Barnaby, Jr., J. W. Bird, A. Talbott Brice, Howard M. Bubert, Theodore R. Shrop, Read N. Calvert, Robert V. Campbell, H. A. Cantwell, J. Albert Chatard, Thomas A. Christensen, John N. Classen, Melvin B. Davis, Everett S. Diggs, Monte Edwards, John S. Fenby, Whitmer B. Firor, Joseph E. Gill, Francis W. Gluck, Wilson Grubb, Jacob C. Handelsman, I. Rivers Hanson, John M. Haws, Gustav Highstein, Harry C. Hull, Marius P. Johnson, George S. M. Kieffer, H. F. Kinnamon, Harry F. Klinefelter, Jr., E. H. Kroman, Bender B. Kneisley, Louis Krause, William B. Long, G. William Martin, Charlotte McCarthy, W. O. McLane, Randall McLaughlin, Claude W. Mitchell, Zachariah E. Morgan, Frank K. Morris, Waldo B. Moyers, S. Edwin Muller, Edmund R. Novak, Charles F. O'Donnell, Thomas R. O'Rourke, Frank J. Otenasek, A. Austin Pearre, Leslie H. Pierce, Maurice C. Pincoffs, Samuel T. R. Revell, Jr., Richard C. Norment, III, Milton S. Sacks, John E. Savage, Louis R. Schoolman, Clifford E. Schott, Richard T. Shackelford, W. Glenn Speicher, James G. Stegmaier, W. Kennedy Waller, William W. Welsh, A. F. Whitsitt, George C. Coulbourn, Palmer F. G. Williams, Walter D. Wise, Theodore E. Woodward.

Dr. M. C. Pincoffs was given the floor and presented to Dr. Kneisley the gavel as "a symbol of the authority that the Faculty has vested in you as President, . . . and it is also a token of the esteem in which you are held." After thanking Dr. Pincoffs and the Society, Dr. Kneisley made the routine announcements concerning registration, privileges of the floor, etc.

The minutes of the previous Semiannual Meeting had been distributed by mail and on motion by Dr. T. A. Christensen, seconded by Dr. Pincoffs, these minutes were approved as mimeographed and circulated.

¹ Key for minutes:

Recommendations and Resolutions are printed in italics.

Motions are printed in "caps" and "small caps."

Action of Resolutions Committee are printed in large italics.

Amendments to Constitution and By-Laws are printed in "caps."

The reports of Officers and Committees were then discussed by the delegates.

UPON MOTION OF DR. C. W. MITCHELL, THE DELEGATES ELECTED TO APPROVE ALL REPORTS AS WRITTEN AND CIRCULATED AS A WHOLE WITH THE EXCEPTION OF THOSE WHICH CARRY RECOMMENDATIONS.

Dr. J. A. Chatard gave a brief review of the financial status of the Faculty and particularly emphasized the summary which has been sent to all members as an enclosure entitled "Fiscal Facts." (See pages 421-429.) He emphasized the inestimable value of the Maryland State Medical Journal and pointed out the comparatively small cost as detailed in "Fiscal Facts." As this report carried no recommendation it had already received approval by the delegates.

Council. (See pages 430-432.) Dr. E. C. Andrus, as Chairman of the Council, reported for the period of January 1, 1954, to the date of this Annual Meeting. He first MOVED THAT EMERITUS MEMBERSHIP BE GIVEN TO THE FOLLOWING:

BALTIMORE CITY:

DR. FRANK J. AYD
DR. E. W. BRIDGMAN
DR. JOHN M. T. FINNEY, JR.
DR. WALTER E. GREMPER
DR. EUGENE H. HAYWARD
DR. KENNETH D. LEGGE
DR. WILLIAM B. SCHAPIRO
DR. HERBERT SCHOENRICH
DR. EDWARD P. SMITH
DR. WILLIAM KELSO WHITE

BALTIMORE COUNTY:

DR. WILLIAM A. BRIDGES

QUEEN ANNE'S COUNTY:

DR. NORMAN S. DUDLEY

THIS WAS SECONDED BY DR. W. B. MOYERS AND CARRIED.

Dr. Andrus pointed out that the Council and the Executive Committee have had two outstanding problems:

1. The change in the Constitution and By-Laws which states that in order to be eligible for benefits of Physicians' Defense, a member must be in good standing at the time of suit and at the time of the alleged act of malpractice. There have been some instances in which the alleged act of malpractice occurred before 1952,—the year in which this change of the Constitution and By-Laws was approved. The Council has been handling such cases on the basis that a member should not be considered ineligible for defense solely because an act which has been alleged to have been committed occurred prior to this change of eligibility. For example: If a member is alleged to have been ineligible in 1945 and the charge occurred in 1953, it is probable that he would be considered eligible for defense as his standing in the Society was satisfactory at the time suit was brought,

and the change in Constitution and By-Laws occurred after the year of alleged malpractice.

2. This problem is also related to eligibility for defense. The accounting practices in the constituent societies have at times been inadequate so that it has been impossible to determine accurately the exact date of payment of the dues by a member and therefore, in these instances, the eligibility of said member for defense. The delegates are requested to convey to their constituent societies these difficulties and to request that some improvement of the accounting practices be made.

Committee on Scientific Work and Arrangements.

(See page 439.) Dr. Beverley C. Compton reported for the Committee on Scientific Work and Arrangements and MOVED THAT THE FOLLOWING BE APPROVED:

THE CONSTITUTION AND BY-LAWS OF THE MEDICAL AND CHIRURGICAL FACULTY PROVIDES FOR THE ELECTION OF A COMMITTEE ON SCIENTIFIC WORK AND ARRANGEMENTS CONSISTING OF THREE MEMBERS. OUR COMMITTEE WISHES TO MAKE A RECOMMENDATION WHICH MAY BE USED FOR A TRIAL PERIOD, AND THEREFORE SUGGESTS THAT IF THIS PROCEDURE IS ADOPTED BY THE HOUSE OF DELEGATES THAT IT BE REFERRED TO THE NOMINATING COMMITTEE TO MAKE ITS SELECTION ACCORDING TO THIS METHOD. THE COMMITTEE ON SCIENTIFIC WORK AND ARRANGEMENTS RECOMMENDS THAT ONE NEW MEMBER BE APPOINTED TO IT EACH YEAR, AND THEREFORE, EACH MEMBER WOULD SERVE FOR A PERIOD OF THREE YEARS. AFTER TWO YEARS OF SERVICE, THE SENIOR MEMBER WOULD AUTOMATICALLY BECOME THE CHAIRMAN FOR A PERIOD OF ONE YEAR ONLY, THEREBY ROTATING THE CHAIRMANSHIP.

THIS WAS SECONDED BY DR. R. N. CALVERT AND CARRIED UNANIMOUSLY.

Dr. Pincoffs requested the floor and MOVED THAT IN VIEW OF DR. COMPTON'S RETIREMENT AS CHAIRMAN ON THE COMMITTEE ON SCIENTIFIC WORK AND ARRANGEMENTS THAT THE HOUSE OF DELEGATES THANK HIM AND HIS COMMITTEE OF DOCTORS WILLIAM L. GARLICK AND EDWIN H. STEWART, JR., FOR THEIR LONG SERVICE ON THIS COMMITTEE AND THE TIME THEY HAVE DEVOTED TO GIVING US GOOD PROGRAMS. SECONDED BY DR. HOWARD M. BUBERT AND CARRIED.

Scientific Speakers Bureau. (See page 460.) Dr. Compton also reported at this time for the Scientific Speakers Bureau of which he is the Chairman. He requested that the delegates bring it to the attention of the component societies that he would appreciate each society submitting to him suggestions for topics and speakers. A revised list of speakers and subjects can then be made available to the component societies.

Diabetes Detection Committee. (See pages 449-450.) The following recommendation of the Diabetic Detection Committee was read by the Secretary:

The activity and scope of this committee has grown year by year and it is now felt that more assistance from the faculty in the way of clerical help and financial aid should be forthcoming if it is desired that this work continue.

ON MOTION OF DR. MOYERS, SECONDED BY DR. M. B.

DAVIS, THIS RECOMMENDATION WAS REFERRED TO THE COUNCIL FOR CONSIDERATION AND ACTION.

Maternal and Child Welfare Committee. (See pages 452-453.) The recommendations from the Committee on Maternal and Child Welfare were read by the Secretary. The first recommendation from the Maternal Section is as follows:

As for specific recommendation, the committee requests that all hospitals in the state, either individually or in a group obtain a supply of "fibrinogen" for use in those occasional cases of afibrinogenemia, more or less peculiar to pregnancy. This product can be life-saving if available and used properly. While moderately expensive, the cost is not prohibitive and the occasion for its use is rare. At the same time that the procurement of this product is urged, the Committee feels that a word of caution is needed to the effect that it can easily be abused, and administered in non-indicated cases. A definite diagnosis of hypofibrinogenemia or afibrinogenemia should first be established.

DR. E. H. KLOMAN MOVED THAT THIS RECOMMENDATION BE ACCEPTED, SECONDED BY DR. FRANK K. MORRIS AND CARRIED.

The second recommendation, which was that of the Pediatric Section is as follows:

The pediatric section also requested that the joint committee urge that Blue Cross coverage be extended to include premature infants. The pediatric section has been advocating this for some time and now urged that both sections collaborate in again bringing this to the attention of the Blue Cross officials.

DR. W. W. WELSH MOVED THAT THIS RECOMMENDATION BE ACCEPTED, SECONDED BY DR. H. F. KLINEFELTER, JR., AND CARRIED.

National Emergency Medical Service. (See pages 455-456.) Dr. John M. Welch, representing Dr. Robert H. Riley, Chairman of the National Emergency Medical Service Committee, read the report with the following recommendations:

It is proposed that the House of Delegates approve the following recommendation to be sent to the president of each county and city medical society of the state:

"In order that the physicians of the state may be kept abreast of current medical progress in Civil Defense and brought up to date relative to their expected role in this program, it is recommended that each of the local societies of this faculty devote, wholly or in part, one of its scheduled meetings during the coming year to the subject of 'The Medical Aspects of Civil Defense.'"

IT WAS MOVED BY DR. G. S. M. KIEFFER, SECONDED BY DR. R. T. SHACKELFORD, THAT THE RECOMMENDATION BE APPROVED. THE MOTION WAS CARRIED.

Tuberculosis Committee. (See page 461.) In the absence of Dr. L. M. Serra, Dr. Otto C. Brantigan gave the report for the Tuberculosis Committee and discussed with the delegates the details of the recommendations. The following action was taken:

Recommendation 1. It is recommended that there be equal opportunity for participation by our two medical schools in the total program of the state tuberculosis hospitals including medical and surgical aspects.

IT WAS MOVED BY DR. W. W. WELSH THAT THE RECOMMENDATION BE ACCEPTED, SECONDED AND CARRIED.

Recommendation 2. It is recommended that a study be made of possibilities for surgical resident physicians of interested state general hospitals to obtain training in thoracic surgery at Mt. Wilson Hospital, chest surgical center of state tuberculosis hospitals.

Dr. Shackelford inquired as to what was meant by the term "interested state general hospitals" to which Dr. Brantigan replied that the intent of the Committee was that this be any private hospital in Baltimore or anywhere in the State and it does not necessarily mean State-controlled hospitals. Dr. Pincoffs pointed out that he felt that the wording of this recommendation implies that the Medical and Chirurgical Faculty has control of these hospitals and that the Faculty would make the study. Actually, the Faculty will express to the State Department of Health the desirability of this recommendation and request that the State Board of Health make a study of the recommendation. THIS RECOMMENDATION ON MOTION OF DR. SHACKELFORD, SECONDED BY DR. PINCOFFS, WAS CARRIED.

Recommendation 3. It is recommended that hospital beds in all tuberculosis hospitals of the state be available to patients regardless of color. This will promote rapid abolition of our waiting lists.

IT WAS MOVED BY DR. I. RIVERS HANSON, SECONDED BY DR. ANDRUS, THAT THIS RECOMMENDATION BE APPROVED.

Recommendation 4. Cases of "open" tuberculosis who refuse isolation create a serious problem. It is recommended that there be a consideration for legal regulations concerning treatment and hospitalization of cases of tuberculosis who are in a communicable state and considered a "public menace."

Dr. Moyers asked if there was at present a law on the statutes concerning the treatment and hospitalization of open cases of tuberculosis. Dr. Brantigan replied that their investigations failed to find a law which would cover this situation, but it was the intent of the Committee to call attention to the fact that generally such laws are not enforced unless there is some means of actually bringing about adequate treatment. He felt there should be some sort of pressure brought about to remove open cases of tuberculosis. DR. MOYERS MOVED THAT THE RECOMMENDATION BE ADOPTED. SECONDED AND CARRIED.

Recommendation 5. It is recommended that there be routine chest x-rays of all hospital and institutional admissions.

Extension of present case-finding procedures should be encouraged.

After questions from the floor, Dr. Brantigan stated that the word "extension" was meant to be very broad and would include such places as the jails, nursing homes, etc., and would also include any place where you would expect to find people housed in close quarters with other individuals. The recommendation is also to apply to every hospital. The initial vote of the delegates on the recommendation was unsettled, and the President asked for a rising vote. THE MOTION WAS CARRIED BY A VOTE OF 31 IN FAVOR OF THE RECOMMENDATION TO 22 OPPOSED TO IT.

Recommendation 6. It is recommended that a similar pattern be urged for other component units of the society to include arrangements with clinics of Baltimore City Health Department, Maryland State Health Department, as well as those of the Maryland Tuberculosis Association.

Upon request Dr. Brantigan clarified the recommendation as follows: A procedure similar to that in effect in Baltimore County is urged for other component units of the Society, such procedure to include arrangements with clinics of Baltimore City Health Department, Maryland State Health Department as well as those of the Maryland Tuberculosis Association. UPON MOTION OF DR. I. RIVERS HANSON, SECONDED BY DR. O'DONNELL, THE RECOMMENDATION AS CLARIFIED BY DR. BRANTIGAN WAS APPROVED.

Board of Medical Examiners of Maryland. (See pages 418, 434, 435.) Dr. E. H. Kroman reported for the Board of Medical Examiners and brought to the attention of the delegates the necessity of changing the Medical Practice Act because of the use of the term "Maryland State Homeopathic Medical Society" in the Act when that Board which is elected by said group no longer exists.

Dr. Kroman also stated that he would like to have consideration given to the insertion into this Act the payment of an annual registration fee by doctors in the State. He further stated that he felt that an increase of the fee for taking the examination would be necessary as there is not a sufficient amount of money obtained from fees to run the Board of Medical Examiners.

Committee on Veterans' Medical Care. (See pages 461-462.) Dr. Ralph G. Hills reported for the Committee on Medical Care of Veterans and pointed out changes which are taking place in connection with the treatment of patients with service-connected disabilities. He had copies of the Tennessee Plan for distribution which he suggested that all members read and call to the attention of their component societies.

Committee for Better Distribution of Doctors Throughout the State. (See page 462.) In the absence of Dr. Allen F. Voshell, the Secretary read the report for the Committee for Better Distribution of Doctors Throughout the State. The following are the recommendations:

1. *That some person in the executive or administrative branch of the faculty be assigned (or employed) to act as director of the services incident to the committee.*
2. *That the committee for the better distribution of doctors in the State of Maryland be assigned to an advisory status for the director.*
3. *That sufficient funds be budgeted to carry out the proper and necessary function of the above services.*

No action was taken.

Committee for the Study of Certain Phases of Medical Economics. Dr. W. B. Moyers reported for the Committee for the Study of Certain Phases of Medical Economics, giving the background of the formation of what the Committee had attempted to do on the State level, and what bills are in Congress which would seem to take care of the problem on a National level if approved. He requested that his Committee be discharged since local action no longer seems to be necessary. IT WAS MOVED BY DR. W. W. WELSH, SECONDED BY

DR. R. N. CALVERT, THAT THIS COMMITTEE BE DISCHARGED, WITH THE APPRECIATION OF THE FACULTY FOR ITS WORK. THIS WAS CARRIED.

Committee to Study Availability of Prepayment Insurance in Rural Areas. (See pages 463-464.) The Secretary, in the absence of Dr. George McLean, presented the report for the Committee to Study Availability of Prepayment Insurance in Rural Areas. This Committee has two projects. (1) To investigate means whereby some type of prepayment insurance, particularly of Blue Cross type, could be made available to the rural areas. (2) To try to work out some means of easing the difficulty that both patients and physicians have in collecting from some of the insurance companies. *Dr. McLean states in his report that a nationwide survey is now being made and he asked for a continuation of his Committee so that it may have the benefit of this survey for a later report.* DR. T. A. CHRISTENSEN MOVED THAT THE REPORT OF THE COMMITTEE AND ITS CONTINUATION BE APPROVED. SECONDED BY DR. W. W. WELSH, AND CARRIED.

The Secretary reported to the House of Delegates a summary of the business to come before the House of Delegates at the afternoon session and pointed out that the complete reports of the officers, committees, etc., would be published as a part of the Transactions in the August issue of the Maryland State Medical Journal.

On motion of Dr. Andrus, seconded and carried, the meeting adjourned at 11:50 a.m.

Respectfully submitted,

EVERETT S. DIGGS, M.D., *Secretary*

FIRST SESSION

Monday, April 26, 1954, 2:00 p.m.

The 209th meeting, of the House of Delegates, First Session, was called to order at 2:00 p.m., in the Deutsches Haus, 1212 Cathedral Street, Baltimore, Maryland, on Monday, April 26, 1954, by the President, Dr. Bender B. Kneisley, presiding.

The following members registered: Drs. Conrad Acton, Warde B. Allen, E. Cowles Andrus, Charles R. Austrian, John W. Barnaby, Jr., J. W. Bird, Howard M. Bubert, Read N. Calvert, Robert V. Campbell, H. A. Cantwell, J. Albert Chatard, Thomas A. Christensen, John N. Classen, Katherine V. Kemp, Melvin B. Davis, Everett S. Diggs, Monte Edwards, John S. Fenby, Whitmer B. Firor, Wetherbee Fort, Joseph E. Gill, Francis W. Gluck, Wilson Grubb, Jacob C. Handelsman, I. Rivers Hanson, John M. Haws, Gustav Highstein, Marius P. Johnson, George S. M. Kieffer, H. F. Kinnamon, Harry F. Klinefelter, Jr., Bender B. Kneisley, William B. Long, G. William Martin, Charlotte McCarthy, W. O. McLane, Randall McLaughlin, Claude W. Mitchell, Zachariah R. Morgan, Frank K. Morris, Waldo B. Moyers, S. Edwin Muller, Edmund R. Novak, Charles F. O'Donnell, A. Austin Pearre, Leslie H. Pierce, Ross Z. Pierpont, Maurice C. Pincoffs, M. C. Porterfield, Samuel T. R. Revell, Jr., Otto C. Brantigan, Richard C. Norment, III, Milton S. Sacks, Louis R. Schoolman, Clifford E. Schott, Richard T. Shackelford, W. Glenn Speicher, James C. Steg-

maier, William W. Welsh, A. F. Whitsitt, Arthur O. Woody, Theodore E. Woodward.

Dr. Kneisley made announcements regarding registration, presentation of motions in writing, identification of delegate by announcement of name and component medical society when addressing the House, etc., and stated that this meeting will open with new business as there is no old business held over from the morning session.

Dr. Kneisley called on Dr. A. A. Pearre, the Chairman of the Committee on Constitution and By-Laws, to present his report. Dr. Pearre announced that a copy of the Constitution and By-Laws, which covers through October 1953, had been distributed for every member. He stated that the following amendments (indicated by capital letters) to the Constitution had been presented to this body and approved on April 28, 1953, but in conformity with the Constitution had to lie on the table for one year before final action could be taken. These amendments had been mailed officially to each Component Society on February 25, 1954. (See pages 448-449.)

ARTICLE V—House of Delegates

Section 2.

The House of Delegates shall consist of (1) delegates elected by the component societies, each component society being entitled to elect one delegate for each 50 active members in good standing, or major fraction thereof; provided each component society shall be entitled to elect at least one delegate; (2) the membership of the Council; (3) ex-officio, the President, the incoming President, the immediate Past President, the Chairman of the Library Committee, the delegates to the House of Delegates of the American Medical Association; and (4) one member elected by the State Board of Medical Examiners.

Amendment:

Delete: (3) EX-OFFICIO, THE PRESIDENT, THE INCOMING PRESIDENT, THE IMMEDIATE PAST PRESIDENT, THE CHAIRMAN OF THE LIBRARY COMMITTEE, THE DELEGATES TO THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION: AND

Change: Number (4) to read (3)

Explanation: This Section has been deleted on recommendation of the Council as ARTICLE VI, Section 2, contains this information. Take note, in this Section, that the following has not been amended: "one member elected by the State Board of Medical Examiners."

ARTICLE VI—Council

Section 2.

The Council shall consist of (1) fifteen Councilors; and (2) the President, the immediate Past President, the President-elect, the Secretary, the Treasurer, and the Chairman of the Library Committee, and Delegates to the American Medical Association House of Delegates, AND CHAIRMAN OF THE COMMITTEE ON CONSTITUTION AND BY-LAWS.

Amendment:

Delete: AND (after Treasurer)

AND (after Committee)

ARTICLE VII—Officers
Section 3.

All officers, except Councilors, shall serve a term of one (1) year. The term of the Councilors shall be for three (3) years from the date of their installation into office, PROVIDED HOWEVER THAT NO COUNCILOR MAY SERVE MORE THAN TWO (2) CONSECUTIVE ELECTED TERMS.

Explanation: The Resolution presented and adopted by the House of Delegates September 1952, regarding terms of Councilors, will be recalled. "Be it Resolved that the Baltimore County Medical Association recommends that the elected members of the Council of the Medical and Chirurgical Faculty of the State of Maryland be limited to two (2) consecutive terms."

(Presented and approved, Wednesday, April 29, 1953.)

ARTICLE VIII—Sessions and Meetings
Section 2.

Special meetings of either the Faculty or the House of Delegates may be called by the President or on petition of 10 delegates or 20 members respectively.

Amendment:

Change: Figure "20" to read: "50"

Explanation: At present, the membership is approximately 2,451, and there are approximately 79 members of the House of Delegates. Our Committee called attention to ARTICLE VIII, Section 2, pertaining to Sessions and Meetings and questioned whether twenty (20) members is not too small a number to petition for special meetings of either the Faculty or the House of Delegates, in view of the growth of the Medical and Chirurgical Faculty, and recommended that the figure be changed to fifty (50).

For your information: The method of adoption is quoted from the Constitution—"ARTICLE XIV—Amendments. The House of Delegates may amend any article of this Constitution by a two-thirds vote of the Delegates present at any Annual Session, provided that such amendment shall have been presented in open meeting at the previous annual, semiannual session or special session, and that it shall have been sent officially to each component society at least two months before the meeting at which final action is to be taken."

DR. KNEISLEY CALLED FOR A VOTE ON THE ABOVE AMENDMENTS TO THE CONSTITUTION AND ON MOTION OF DR. H. M. BUBERT THAT THE CHANGES MADE IN THE CONSTITUTION BE ACCEPTED, SECONDED BY DR. M. C. PORTERFIELD, THESE AMENDMENTS WERE UNANIMOUSLY ADOPTED.

Dr. Pearre presented the following amendment, (in capitals) which is the result of the study made by a special committee appointed by Dr. M. C. Pincoffs, then President, in November 1953. (See pages 405, 448, 449.)

The By-Law reads at present:

The dues of a licensed physician in Maryland who holds an academic position on a full time salary basis, other than as a fellow or house officer, shall be \$15.00 per annum during the first five years of his academic position.

It is proposed that this section be amended to read as follows:

THE DUES OF A LICENSED PHYSICIAN IN MARYLAND WHO HOLDS AN ACADEMIC POSITION ON A STRICT FULL TIME SALARY BASIS, OTHER THAN AS A FELLOW OR HOUSE OFFICER, SHALL BE \$10.00 PER ANNUM AS LONG AS HE HOLDS A RANK BELOW THAT OF AN ASSOCIATE PROFESSOR.

Dr. Pearre read the justifications by Dr. Palmer H. Fitcher and his Committee for such an amendment:

Justifications: With rare exceptions, the maximum professional income of full time teachers referred to in this section, as amended is \$8,500; the salaries of many are considerably less than this figure. These men graduated from medical school five years or more ago. Some of these young men remain in full time academic positions for the full course of their professional careers; hence, the maximum income to which they can look forward is not as high as that of many men engaged predominantly in private practice.

Our suggested specification of the specific rank below "Associate Professor" clears up former ambiguity implicit in "during the first five years of his academic position."

Twenty members of the clinical faculty at Hopkins and nine at Maryland fall into the category covered by the amendment. Twenty-two of the twenty-nine now hold some form of membership in the State Society. Thus the group involved is small, relative to the total membership of 2600 in the State Society. It is important that the Faculty assure participation by these men in the activities of their Medical Society. This group contributes to the state and local societies by participation in their meetings, where they present data on recent advances in scientific medicine. Further, since these men are active teachers, it is important that their liaison with the problems of a wide group of practitioners be close. Encouragement of membership in the societies and participation in their various activities will promote this liaison.

The proposed dues are nominal, being \$10.00 for the men in this category. The balance between this amount and the full dues will actually be contributed by the much larger group of members of the State Society, who pay full dues. It is contemplated that the members of the Society will appreciate that, in offering this group of teachers full membership for \$10.00, they are in fact, making a contribution to the State's two medical schools. For, by maintaining the dues at a nominal level, they will contribute to maintaining the personal professional expenses of this group of young men at a low level, thereby rendering more attractive to young men these important teaching positions in the schools and assisting the recruitment of men for these positions.

Dr. Pearre informed the House that in conformity with the By-Laws final action will be taken by this body on this amendment, if approved, on Wednesday morning, April 28, 1954 meeting.

The question was asked whether these physicians had to take the State Board examinations. Dr. Kneisley stated that the physicians in this group are active members and only

licensure is necessary for active membership. The dues are less for this special category.

DR. HARRY F. KLINEFELTER, JR., MOVED THAT THE RECOMMENDATION BE ACCEPTED, SECONDED BY DR. JOHN M. HAWS AND CARRIED.

Dr. Pearre requested comments and authorization for his Committee to have instructions or approval from the House of Delegates to have the Constitution and By-Laws of the Faculty reviewed from the standpoint of clarification and pure English but in no way to change the effect of the Constitution. His Committee would want the privilege of having the assistance of members of the Faculty, whom Dr. Pearre felt were better versed than he along these lines.

Dr. Pearre answered Dr. Acton's suggestion for a parliamentarian, that to have one in such an official capacity would be helpful. No definitive action was taken by the House on Dr. Pearre's request.

Resolutions Committee

Dr. Robert V. Campbell, Chairman of the Resolutions Committee made his report.

Resolution I.

Resolved that whereas the Medical and Chirurgical Faculty of Maryland building is in need of remodeling and additional space for meeting rooms and its library, together with the necessity of refurbishing and refurnishing its quarters, and whereas a number of the city and county members have voluntarily pledged sums of money to the extent of approximately \$80,000 and, whereas an additional sum of money amounting to \$220,000 or more is necessary, be it resolved that an amount of money should be contributed in the form of an assessment by each member of the Medical and Chirurgical Faculty.

The assessment should be arranged in the following manner.

1. *All members of the City and State Medical Society should be assessed an amount of \$150.*
2. *All members of the County and State Medical Society should be assessed an amount of \$100.*

Members who have already pledged an amount equal to the above as the case may be should be exempt from any assessment excepting in those cases where the amount pledged is not equal to the above mentioned amounts, then assessments should be for only the difference.

Assessments should be made at the rate of \$10 per year until the full amount is paid. Should any member desire to pay larger amounts in any one year he may have this privilege.

THE RESOLUTIONS COMMITTEE FELT THAT THIS RESOLUTION IS OF SUCH IMPORT THAT IT SHOULD BE ACTED UPON WITHOUT PREJUDICIAL DECISION BY SAID COMMITTEE.

Dr. Whitmer B. Firor stated that at the meeting of the Resolutions Committee, it was suggested that line 2, paragraph 3, which at present reads:

Members who have already pledged an amount equal to the above as the case may be should be exempt from any assessment excepting in those cases, etc., etc., should have the word any changed to *THIS*.

This recommendation was acceptable to Dr. Goldstein.

Dr. Kneisley asked Dr. Goldstein to discuss his recommendation and to answer questions presented by the delegates. Dr. Goldstein pointed out that if there is to be a new building or an annex to the old one, a more definite program for collecting the funds must be found and if over a period of years this money can be collected on an assured basis, it may be possible to obtain a loan and start with the building.

Doctors R. B. Norment, G. S. M. Kieffer, H. F. Klinefelter, Jr., R. T. Shackelford, W. O. McLane, Jr., J. C. Handelsman, Conrad Acton, asked questions and discussed the following: Whether the method of collection should be included with dues as an assessment; whether the younger doctors just entering practice should immediately start payments; if one were ill, or deceased, if estate would be liable for complete amount; should academic members, etc., who have reduced rate of dues, pay full pledge; and would those who later become members have to pay a full ten years.

In brief, Dr. Goldstein said he would leave it to the delegates as to the method of collection for the various groups but he felt that academic members, etc., should be assessed like all others; that in case of illness, etc., it was not necessary to complete payments; that the idea had been to assess only to time of complete amortization, but if newly elected members continue to pay for ten years, it would increase the treasury towards upkeep of the building.

DR. HARRY C. HULL MOVED THAT THE RESOLUTION BE ACCEPTED, SECONDED BY DR. MONTE EDWARDS.

Dr. W. B. Moyers, representing the Prince George's County Medical Society, made an impressive talk for his Society urging that the delegates consider the necessity of a strong State Society, calling attention to the support and help that a Component or individual receives from the Medical and Chirurgical Faculty and recommended that it not be an assessment but the wording be changed to DUES.

This was seconded by Dr. T. A. Christensen.

Doctors J. A. Chatard, E. S. Diggs, Monte Edwards, H. M. Bubert, M. C. Pincoffs, A. E. Goldstein, E. C. Andrus, L. R. Schoolman, M. P. Johnson and Mr. W. N. Kirkman discussed the advantages and disadvantages of having the building fund made available through the collection of "assessments" or "dues."

Dr. Kneisley stated that the motion before the House, as presented by Dr. Moyers, is that the resolution be amended so that the ten dollar increase be obtained on the basis of increased annual dues for each member.

The motion of the Prince George's County Medical Society to amend the resolution was defeated.

THE ORIGINAL MOTION OF DR. HARRY C. HULL, THAT THE RESOLUTION AS PRESENTED BE ACCEPTED, WHICH HAD BEEN SECONDED, WAS UNANIMOUSLY CARRIED.

The Secretary asked Dr. Goldstein if he would like specific instructions from the House of Delegates regarding assessment of new members. This elicited discussion by Dr. Conrad Acton who moved that the assessment should terminate at the end of the tenth year, and that for new members their assessment would begin after three years in the Society. This was seconded.

Dr. M. C. Pincoffs and Dr. M. P. Johnson amended Dr.

Acton's motion that the assessment shall cease after 1969 in the case of Baltimore City members and 1964 in the case of County members. This would mean an assessment of ten dollars a year for ten years for County members, and ten dollars a year for fifteen years for the City members. Dr. Andrus pointed out that Dr. Acton referred to the first three years of membership and the Constitution and By-Laws states dues apply to first three years in practice.

DR. ACTON REWORDED HIS MOTION, WHICH HAD BEEN SECONDED, THAT THE COLLECTION OF THIS ASSESSMENT SHALL NOT BEGIN UNTIL AFTER THE DOCTOR HAS BEEN IN PRACTICE FOR THREE YEARS. IF HE BECOMES A MEMBER AFTER HE HAS BEEN IN PRACTICE THREE YEARS, THE ASSESSMENT SHOULD BEGIN WHEN HE BECOMES A MEMBER. UNANIMOUSLY CARRIED.

DR. M. P. JOHNSON MOVED THAT THIS ASSESSMENT NOT BE LEVIED ON BALTIMORE CITY MEMBERS AFTER 1969 AND ON ALL OTHER COMPONENT MEDICAL SOCIETIES NOT AFTER 1964. SECONDED BY DR. H. F. KLINEFELTER, JR., AND UNANIMOUSLY CARRIED.

Resolution II.

Dr. Campbell announced that the following resolution, sponsored by the Radiological Section of the Baltimore City Medical Society and the Maryland Radiological Society, had been considered by the Resolutions Committee:

Whereas, health insurance has been accepted by the public and the medical profession as a means of meeting the cost of medical care, in whole or in part, and

Whereas, the members of the American Medical Association, state and county medical societies are bound by the code of ethics of the American Medical Societies, and

Whereas, the American Medical Association has repeatedly defined radiology, pathology and anesthesiology as the practice of medicine, and not as an ancillary hospital service, and

Whereas, certain insurance carriers, including Blue Cross, have sold medical care policies to industrial and commercial firms, which provide payment for radiological and other medical services, as hospital services, and

Whereas, the House of Delegates of the American Medical Association, on December 3, 1953, unanimously adopted a resolution which emphatically criticized recent contracts signed by Blue Cross with several meat packers, and condemned all insurance contracts classifying medical services as hospital services, and

WHEREAS, BLUE SHIELD PLAN REPRESENTATIVES ON JANUARY 16-17, 1954, AT THEIR CHICAGO MEETING, ADOPTED UNANIMOUSLY A RESOLUTION WHICH RESOLVED, IN PART, AS FOLLOWS: BLUE SHIELD PLANS HEREBY AFFIRM THE DEFINITIONS OF THE PRACTICE OF MEDICAL SERVICES AS SET FORTH IN THE OFFICIAL ACTIONS OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION, AND

Whereas, these problems have been satisfactorily solved in certain localities (for example, Nebraska and Kansas City, Missouri areas) and the Blue Cross-Blue Shield

differentiation of medical and hospital services maintained; therefore, be it

Resolved, that all health insurance carriers, including Maryland Hospital Service, Inc. and Maryland Medical Service, Inc., should formulate their medical policies in strict adherence to the principles set forth by the American Medical Association; and be it further

Resolved, that the Medical and Chirurgical Faculty of Maryland go on record as opposed to any contract between Maryland Hospital Service, Inc. and Maryland Medical Service, Inc. and any corporation or group of employees which does not differentiate between hospital and medical services as set forth in the paragraphs above; and be it further

Resolved, that the Medical and Chirurgical Faculty of Maryland requests that negotiations be undertaken immediately between representatives of the medical profession and Maryland Hospital Service, Inc. and Maryland Medical Service, Inc. in an effort to properly classify hospital services under Blue Cross and medical services under Blue Shield, and that further negotiations be undertaken to formulate a plan for complete medical coverage under Blue Shield to be presented to large group insurance buyers.

DR. CAMPBELL STATED THAT THE RESOLUTIONS COMMITTEE APPROVES IN PRINCIPLE THE RESOLUTION SPONSORED BY THE RADIOLOGICAL SECTION OF THE BALTIMORE CITY MEDICAL SOCIETY AND THE MARYLAND RADIOLOGICAL SOCIETY, AND RECOMMENDS THAT THE PRESIDENT APPOINT A COMMITTEE EMPOWERED TO ACT TO CONFER WITH THE MARYLAND MEDICAL SERVICE, INC., AND THE MARYLAND HOSPITAL SERVICE, INC.

Dr. W. B. Firor urged the delegates to act promptly on this resolution as Blue Shield is writing a new contract for an industrial group of metal workers. HE MOVED THAT THE PRESIDENT APPOINT A COMMITTEE TO MEET WITH BLUE CROSS AND BLUE SHIELD TO DISCUSS THIS PROBLEM. SECONDED BY DR. CHARLES F. O'DONNELL AND CARRIED.

Dr. Kneisley explained that Dr. Henry F. Ullrich has succeeded Dr. Hugh J. Jewett as President of the Maryland Medical Service, Inc.

Mr. R. H. Dabney, Director of Maryland Medical Service—Maryland Hospital Service, Inc., addressed the delegates regarding the reason for the new type of possible contract that had been sent to the doctors, who are participating in the Plan. He said he would be glad to answer any questions. Some discussion followed.

DR. MARIUS P. JOHNSON MOVED THAT A COMMITTEE BE CREATED TO REVIEW THE PRESENT AND FUTURE USE OF THE PHYSICIANS OF THE STATE OF MARYLAND IN RELATION TO THE MARYLAND MEDICAL SERVICE AND MARYLAND HOSPITAL SERVICE, INC., AND TO MAKE RECOMMENDATIONS TO THE MEDICAL AND CHIRURGICAL FACULTY THAT WILL BE SATISFACTORY TO THE PUBLIC AND PHYSICIANS. SECONDED BY DR. MAURICE C. PINCOFFS.

In the discussion Dr. Andrus pointed out that the Maryland Medical and Maryland Hospital Services are incorpo-

rated. The influence of the physicians on that body is limited, although the Medical and Chirurgical Faculty appoints members to various Boards, Committees, etc., and included among these appointees are some of the members of the Medical Relations Committee. If this body does adopt the pending motion, Dr. Andrus urged that the Faculty Committee and the Medical Relations Committee collaborate as closely as possible.

DR. GRUBB MOVED THAT DR. JOHNSON'S MOTION BE AMENDED TO INCLUDE THAT THERE BE EQUAL REPRESENTATION ON THIS COMMITTEE OF THE LAITY, SURGEONS AND MEDICAL MEMBERS (NON-SURGICAL), AND THAT DUE CONSIDERATION BE GIVEN GEOGRAPHICALLY WHEN MAKING UP THE COMMITTEE. SECONDED BY DR. I. RIVERS HANSON AND CARRIED UNANIMOUSLY.

DR. KNEISLEY REPEATED DR. JOHNSON'S MOTION, WHICH HAD BEEN SECONDED BY DR. PINCOFFS, AND CALLED FOR THE VOTE ON IT. UNANIMOUSLY CARRIED.

The House adjourned for a five minute recess.

Respectfully submitted,

EVERETT S. DIGGS, M.D., *Secretary*

SECOND SESSION

Monday, April 26, 1954

The 210th meeting of the House of Delegates held on Monday, April 26, 1954, was reconvened after a five minute recess, and Dr. Bender B. Kneisley, the President, called the Second Session to order.

Dr. Wetherbee Fort, Chairman of the Nominating Committee, announced that he had the privilege and pleasure of presenting the following slate. All nominees have been contacted and agree to serve if elected:

NOMINATIONS FOR 1955

<i>President</i>	George H. Yeager, Baltimore
<i>Vice-Presidents</i>	Waldo B. Moyers, Hyattsville
	Samuel Whitehouse, Baltimore
	Charles J. Foley, Havre de Grace
<i>Secretary</i>	Everett S. Diggs, Baltimore
<i>Treasurer</i>	J. Albert Chatard, Baltimore
	Leo Brady, Baltimore (1957)
	Thomas A. Christensen, College Park (1957)
<i>Councilors</i>	Warfield M. Firor, Baltimore (1957)
	Whitmer B. Firor, Baltimore (1957)
	Clewell Howell, Towson (1957)
	Ross L. McLean, Baltimore (1957)
	Norman E. Sartorius, Jr., Pocomoke City (1957)
<i>Delegate to American Medical Association</i>	Warde B. Allan, Baltimore (1955-1956)
<i>Alternate Delegate to American Medical Association</i>	Louis H. Douglass, Baltimore (1955-1956)

<i>Committee on Scientific Work and Arrangements</i>	Edmond J. McDonnell, Chairman, Baltimore
	Beverley C. Compton, Baltimore
	Norman R. Freeman, Jr., Baltimore
<i>Library Committee</i>	Lester A. Wall, Jr., Baltimore (1959)
<i>Finney Fund Committee</i>	Henry J. L. Marriott, Baltimore (1959)

<i>Board of Medical Examiners</i>	Wylie M. Faw, Jr., Cumberland (1958)
	Lewis P. Gundry, Baltimore (1958)

Nominating Committee

Wetherbee Fort, *Chairman*, Baltimore
 George O. Eaton, Baltimore
 Page C. Jett, Prince Frederick
 James T. Marsh, Westminster
 John M. Scott, Baltimore

Dr. Kneisley asked for nominations from the floor and as there were none he announced that the nominations were closed. The elections take place at the Third Session of this body on Wednesday, April 28, 1954, 9:30 a.m. in the Deutsches Haus, Second floor Auditorium, WITH THE EXCEPTION of the elections for the Board of Medical Examiners, who are elected at the General Meeting of the Medical and Chirurgical Faculty at 12:00 noon in Osler Hall on Tuesday, April 27, 1954. The two members on the Board of Medical Examiners nominated by this body are Dr. Wylie M. Faw, Jr., Cumberland, and Dr. Lewis P. Gundry, Baltimore—but there may be other nominations from the floor. (See page 418.)

Dr. Kneisley announced that the third and last session of the House of Delegates will be at 9:30 a.m. on Wednesday, April 28, 1954. He thanked Dr. Diggs and the Office Staff for arranging the agenda.

The meeting adjourned at 4 p.m.

Respectfully submitted,

EVERETT S. DIGGS, M.D., *Secretary*

THIRD SESSION

Wednesday, April 28, 1954, 9:30 a.m.

The 211th Meeting of the House of Delegates, Third Session, was held at the Deutsches Haus, 1212 Cathedral Street, on Wednesday, April 28, 1954, at 9:30 a.m., and was called to order by the President, Dr. Bender B. Kneisley, Presiding.

The following members registered: Drs. Conrad Acton, Philibert Artigiani, John W. Barnaby, Jr., J. W. Bird, Howard M. Bubert, Read N. Calvert, H. A. Cantwell, J. Albert Chatard, Everett S. Diggs, Monte Edwards, John S. Fenby, Whitmer B. Firor, Wetherbee Fort, Joseph E. Gill, Francis W. Gluck, I. Rivers Hanson, John M. Haws, Harry C. Hull, Page C. Jett, Marius P. Johnson, H. F. Kinnamon, Harry F. Klinefelter, Jr., Bender B. Kneisley, Louis Krause, William B. Long, Randall McLaughlin, J. Duer Moores, Claude W. Mitchell, Zachariah R. Morgan, Frank K. Morris, Waldo B. Moyers, S. Edwin Muller, Charles F. O'Donnell, A. Austin Pearre, M. C. Porterfield, Samuel T. R. Revell, Jr., Peter P. Rodman, John M. Scott, Louis R. Schoolman, Richard T.

Shackelford, M. Glenn Speicher, James C. Stegmaier, William W. Welsh, A. F. Whitsitt.

Dr. Kneisley made the routine announcements regarding registration, etc. He then asked the Secretary to read the list of nominees.

The following officers, etc., on motion of Dr. Frank K. Morris, seconded by Dr. Wetherbee Fort, and unanimously carried were elected:

- President..... George H. Yeager, Baltimore
- Vice-Presidents..... { Waldo B. Moyers, Hyattsville
Samuel Whitehouse, Baltimore
Charles J. Foley, Havre de Grace
- Secretary..... Everett S. Diggs, Baltimore
- Treasurer..... J. Albert Chatard, Baltimore
Leo Brady, Baltimore (1957)
Thomas A. Christensen, College Park (1957)
- Councilors..... { Warfield M. Firor, Baltimore (1957)
Whitmer B. Firor, Baltimore (1957)
Clewell Howell, Towson (1957)
Ross L. McLean, Baltimore (1957)
Norman E. Sartorius, Jr., Pocomoke City (1957)
- Delegate to American Medical Association. Warde B. Allan, Baltimore (1955-1956)
- Alternate Delegate to American Medical Association..... Louis H. Douglass, Baltimore (1955-1956)
- Committee on Scientific Work and Arrangements..... { Edmond J. McDonnell, Chairman, Baltimore
Beverley C. Compton, Baltimore
Norman R. Freeman, Jr., Baltimore
- Library Committee.... Lester A. Wall, Jr., Baltimore (1959)
- Finney Fund Committee. Henry J. L. Marriott, Baltimore (1959)

Dr. Kneisley said there was one matter under old business and requested the Secretary to read the amendment (follows) to the By-Laws which had been presented to the House of Delegates at the previous meeting by the Chairman of the Committee on Constitution and By-Laws (see pages 448-449.)

THE DUES OF A LICENSED PHYSICIAN IN MARYLAND WHO HOLDS AN ACADEMIC POSITION ON A STRICT FULL-TIME SALARY BASIS, OTHER THAN AS A FELLOW OR HOUSE OFFICER, SHALL BE \$10.00 PER ANNUM AS LONG AS HE HOLDS A RANK BELOW THAT OF AN ASSOCIATE PROFESSOR.

DR. M. C. PORTERFIELD MOVED THAT THE AMENDMENT BE ADOPTED, SECONDED BY DR. HARRY C. HULL AND UNANIMOUSLY CARRIED.

Dr. J. W. Bird called to the attention of the House that no action had been taken in reference to the statement made on Monday morning at Special Session by Dr. E. H. Kloman, Secretary of the Board of Medical Examiners. As Dr. Kloman does not wish to continue as a member of the Board after his tenure of office expires in 1955, Dr. Bird wished to take a little recognition of the point mentioned by Dr. Kloman. (See page 412.)

DR. BIRD MOVED THAT AS A RESULT OF THE SUGGESTIONS OF DR. E. H. KLOMAN, SECRETARY OF THE BOARD OF MEDICAL EXAMINERS, THAT A COMMITTEE BE APPOINTED TO CONFER WITH THE BOARD OF MEDICAL EXAMINERS, TO MAKE A STUDY REGARDING THE ANNUAL REGISTRATION OF PHYSICIANS IN MARYLAND AND REPORT ITS FINDINGS TO THE HOUSE OF DELEGATES IN OCTOBER 1954. SECONDED BY DR. H. A. CANTWELL, AND CARRIED.

Dr. Diggs informed the delegates that this same idea had emanated from the Secretaries and Journal Representatives meeting. However, the Council did not feel it could be worked out. At the present time no accurate list of physicians actively practicing in Maryland is available to either the Medical and Chirurgical Faculty, or to the Board of Medical Examiners. According to the Constitution and By-Laws the Faculty is required to have such a list.

As there was no other business, the meeting adjourned at 9:55 a.m.

Respectfully submitted,
EVERETT S. DIGGS, M.D., Secretary

GENERAL MEETING

Tuesday, April 27, 1954

12:00 Noon, Osler Hall

Election of State Board of Medical Examiners of Maryland

The election for two new members of the Board of Medical Examiners of Maryland was held at 12:00 noon, Tuesday, April 27, 1954. The meeting was called to order by the President, Dr. Bender B. Kneisley. Two nominations were introduced from the House of Delegates, which nominated Drs. Wylie M. Faw, Jr. and Dr. Lewis P. Gundry. Nominations were requested from the floor.

There being no additional nominations, it was moved, seconded, and unanimously carried, that the following be elected to the Board of Medical Examiners of Maryland: Dr. Wylie M. Faw, Jr., Cumberland (1958) and Dr. Lewis P. Gundry, Baltimore (1958). The Secretary was asked to cast the ballot.

REPORTS^{1, 2, 3}*To the House of Delegates*

SECRETARY'S REPORT

Mr. President and Members of the House of Delegates:

The complete statistical report of the Secretary is attached. In summary, there are 1,426 members in Balti-

more, and 1,082 in the County Societies, making a total of 2,508.

The following Component Medical Societies sent in dues for every member by January 31, 1954: Calvert County, Caroline County, Charles County, Dorchester County,

Secretary's Report

April, 1954

Member-ship 1953	Member-ship 1954	Paid in Advance	Counties	U. S.* Service	New Members	Re-moved	Re-signed	De-ceased	Drop-ped
78	76	57	Allegany-Garrett County Medical Society	3	3	2	2		1
56	60	56	Anne Arundel County Medical Society	1	6	1		1	
153	164	92	Baltimore County Medical Society	1	15	2	2		
1336	1349	1125	Baltimore City Medical Society, Active	25	64	15	8	25	3
92	77	53	Baltimore City Medical Society, Associate		10	11	10	1	3
6	5	5*	Calvert County Medical Society				1		
11	11	10*	Caroline County Medical Society	1					
37	38	31	Carroll County Medical Society		2			1	
20	20	18	Cecil County Medical Society, Active	2	1	1			
7	7	4	Cecil County Medical Society, Associate		1	1			
15	12	11*	Charles County Medical Society	1		2	1		
23	27	27*	Dorchester County Medical Society		5	1			
53	55	55*	Frederick County Medical Society	1	4	2			
31	33	29	Harford County Medical Society	1	2				
10	10	9	Howard County Medical Society						
13	14	11	Kent County Medical Society	1	3			2	
171	185	146	Montgomery County Medical Society, Active	2	24	4	2	3	1
9	14	9	Montgomery County Medical Society, Asso.		5				
78	80	66	Prince George's County Medical Society, Active	3	6		3	1	
29	27	18	Prince George's County Medical Society, Asso.				2		
10	8	8*	Queen Anne's County Medical Society			2			
15	14	13	St. Mary's County Medical Society					1	
13	10	9	Somerset County Medical Society			2		1	
28	27	25*	Talbot County Medical Society	2				1	
72	75	72	Washington County Medical Society	1	4	1			
49	51	44	Wicomico County Medical Society		5	1		2	
14	14	12	Worcester County Medical Society		1			1	
41	45	34	Non-resident Members		9	1	3		1
2470	2508	2049		45	170	49	34	40	9

Gain—Active Members..... 46

Gain-Nonresident Members..... 4

50

Loss—Associate Members..... 12

ACTUAL GAIN..... 38 members

Active members..... 2338

Associate members..... 125

Non-residents..... 45

2508

* U. S. Service members included in 1954 count.

¹ A summary of these reports, which were submitted by the Officers, Chairman of the Council, A.M.A. Delegates, and the Chairman of the Committees, was mailed to every Delegate and the President and Secretary of each Component Society

prior to the meeting of the House of Delegates on Monday, April 26, 1954.

² For Resolutions, Reports, etc. submitted on Monday, April 26, 1954, see pages 413-417.

³ Membership Roster for March 31, 1953 to March 31, 1954, published in May 1954 Journal.

Frederick County, Howard County, Queen Anne's County, Somerset County, and Talbot County.

At one time the Secretaries of the Component Medical Societies met during the Annual Meeting, but for several years such meetings have not been held. This year this practice was resumed on a luncheon basis. As an experiment, and due to the fact that a good many of the Journal Representatives are also Secretaries, a joint luncheon meeting was held on Wednesday, March 31, 1954. Judging from the comments that have been made, this was successful and the desire has been expressed that this procedure be continued. A digest of the meeting will be sent to all Component Secretaries.

A current project is the development of a standard application form for use by all the Component Medical Societies. A tentative form was distributed to the Secretaries. On the basis of their suggestions, a new form will be sent out for the approval or disapproval of each of the Component Societies.

As a further project of the immediate future, it is hoped that a Faculty clearing office will be established whereby dates of all medical meetings in the State may be filed. Future meetings of medical groups, whether they be sectional, regional, hospital, or State Society, could then be planned accurately with the least possible chance of conflict with other meetings already scheduled.

It seems probable at this time that all of the back Transactions of the State Society will be ready for publication by the end of the year. This will complete a long standing, arduous job of bringing all Transactions up to date.

It is the desire of the Secretary that there be a close liaison between the Component Societies. This may best be maintained by the concentrated effort of the Faculty office offering you its services, and by your representatives informing the State Society of your problems and needs.

As a result of the increase in dues, we are now able to increase the secretarial staff, and should soon be in a position to give greater assistance to the Component Societies and to the committees, thereby enabling them to be more active. From the inauguration of the Journal in 1951 until the last few weeks, all of the stenographic work has been assumed by the office staff. With the recent employment of a full time stenographer for the Journal, the office staff is released for more concentrated effort in the work of the Faculty.

During the several years that I served as Assistant Secretary under Dr. Yeager, I was able to become familiar with the work of the Faculty. However, it is only through the close contact made possible by assuming this office on January 1st of this year that the enormity of the business transacted by the State Society is fully realized.

I earnestly solicit your continued cooperation in helping the State Society office serve each and every Component and its members to the greatest extent possible.

Respectfully submitted,

EVERETT S. DIGGS, M.D., *Secretary*

REPORT OF J. ALBERT CHATARD, M.D., TREASURER*

Mr. President and Members of the House of Delegates:

You have copies of the Financial Report of the Treasurer showing in detail the receipts and expenditures for the year 1953. (See pages 421-428.)

The actual amount of money that has to be spent and accounted for is, I am sorry to say, realized by only a few members. The figures are all there to be assimilated and digested so that you may know just what the Faculty is doing. We have now a Finance Committee and a Budget Committee to supervise the expenditures, and plan the activities of next year. Please try to see and follow what is being done with your dues and various funds. "Fiscal Facts" (page 429) and the budget (page 445) will give this information. One of the duties of the Finance Committee is to estimate the revenues, which amount is given to the Budget Committee. The latter Committee prepares the budget of disbursements, and the entire budget of revenue and disbursements is reviewed by the Finance Committee and submitted to the Council for its consideration.

I have been your Treasurer for about fifteen years, and although repeatedly asking to be relieved from this office, you have kindly had my name kept on the list of nominations each time. I have been a member of the Faculty now for fifty years, and have asked the Council to appoint an Assistant Treasurer. The Council allowed me to suggest the name of Dr. Wetherbee Fort for this new post, and he has been appointed as such.

Dr. Fort has been such an ardent and able member of the Faculty, and has done such splendid work the last few years, and I feel he will be an asset of great help in the financial work and plans in the future.

My work as your Treasurer has been very little compared to the great help from your Director and the Office Force, without which the wheels would soon stop running. I extend to them my heartiest thanks and great appreciation for what they have done. The same wishes I would like to extend to all the members, for their trust in me and their cooperation in the complicated financial needs of the Faculty.

I am sorry I have so often found it necessary to ask for more money, but alas to only too few is known what a big financial burden we have absorbed and must carry on in the way our former members would wish us to do.

Again, I thank you for your support, and see the future growth of the Faculty as a bright and shining example to the many other State Societies. We have a background of medical tradition and ancestors, we have a membership assuming the present needs, and we have a future goal that must be reached.

Respectfully submitted,

J. ALBERT CHATARD, M.D., *Treasurer*

* Also includes the Report of the Finance Committee.

THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

Baltimore, Maryland

GENERAL FUND—INCOME AND EXPENSE STATEMENT

For Year Ended December 31st, 1953

(Prepared from Records after Partial Audit)

Income

Dues—Baltimore City Dental Society	\$ 1,410.00	
—Baltimore City Medical Society	38,866.00	
—County Medical Societies	16,978.50	
—Halls and Offices—Baltimore City Medical Society	400.00	
—Halls and Offices—Other	4,595.00	\$62,249.50
		<hr/>
Membership Assessments		17,140.00
Meetings—Annual and Semi-Annual—Exhibits		4,075.00
Baltimore City Medical Society—For Salaries		3,100.00
American Medical Association—For General Purposes		444.50
Journal—Advertisements	17,359.01	
—Subscriptions	3,677.75	21,036.76
		<hr/>
<i>Transfers from Consolidated Fund—Income Funds</i>		
Charles M. Ellis Fund—For General Purposes	1,072.21	
John Ruhrah Fund—For Salaries	300.00	1,372.21
		<hr/>
Miscellaneous Income		27.46
		<hr/>
Total Income		\$109,445.43

Expense

Accounting Fees		405.75
Communication Expense—Postage, Telephone and Telegraph		3,156.37
Contributions—National Society for Medical Research	50.00	
—“Aces and Deuces”	70.00	120.00
		<hr/>
Extraordinary Repairs		1,398.69
Fuel		2,582.35
Gas, Electricity and Water		2,209.10
Household and Janitorial Supplies		515.37
Insurance		1,272.27
Interest Expense		266.59
Journal Expense		19,444.24
Legal Fees		751.44
Legislative Committee Expense		51.30
Library Account—Supplies and Expense		72.58
Maintenance of Property		1,459.16
Maryland Unemployment Insurance		82.82
Federal Unemployment Insurance		122.76
Social Security Tax		1,362.59
Meetings—Annual and Semi-Annual		5,319.27
Miscellaneous Expense		3,193.43
Purchase of Equipment		565.54
Office Supplies		1,058.88
Printing—Transactions of the Faculty	854.50	
—Other	1,658.49	2,512.99
		<hr/>
Salaries		48,250.10
Travel		412.04
		<hr/>
Total Expense		96,585.63
		<hr/>
Excess of Income Over Expense—For Year Ended December 31st, 1953—to Exhibit C		12,859.80
		<hr/>

GENERAL FUND—SURPLUS ACCOUNT

January 1st, 1953 to December 31st, 1953

(Prepared from Records after Partial Audit)

January 1st, 1953—Balance to Debit of Account—Deficit \$ 6,179.62

Addition

Excess of Income over Expense—For Year Ended December 31st, 1953—Exhibit B. 12,859.80

December 31st, 1953—Balance to Credit of Account—To Exhibit A. 6,680.18

CONSOLIDATED FUND—INCOME FUNDS—INCOME AND EXPENSE STATEMENT

For Year Ended December 31st, 1953

(Prepared from Records after Partial Audit)

*Income**Income from Consolidated Fund Investments**Bonds*

United States Government and Municipal.	\$ 970.50	
Public Utility, Railroads, etc.	915.00	\$ 1,885.50

Stocks

Common.	7,878.87	
Preferred.	402.88	8,281.75

Interest Special Savings Account—Maryland Trust Company. 13.40

10,180.65

Less—Agencies Fees. 415.47

Net Income from Investments—Exhibit F. \$ 9,765.18

Interest on Savings Accounts—Maryland Trust Company—Exhibit F. 200.75

Sale of Cakes—Exhibit F. 2.40

Total Income. 9,968.33

Expense—Exhibit F

Special Purposes. 141.76

Library Purposes. 8,438.85

General Purposes. 381.00

Transfers to General Fund—Salaries. 300.00

—General Purposes. 1,072.21 1,372.21

Total Expense. 10,333.82December 31st, 1953—Excess of Expense over Income—To Exhibit E. 365.49

CONSOLIDATED FUND—INCOME FUNDS BALANCE

January 1st, 1953 to December 31st, 1953

(Prepared from Records after Partial Audit)

January 1st, 1953—Balance to Credit of Account. \$26,648.19

Addition

Transfer of Nellie N. Cowles Income Fund—Exhibit K. 31.11

26,679.30*Deduction*

Excess of Expense over Income—For Year Ended December 31st, 1953—Exhibit D. 365.49

December 31st, 1953—Balance to Credit of Account—to Exhibit A. 26,313.81

CONSOLIDATED FUND—INCOME FUNDS
RECEIPTS, EXPENDITURES AND BALANCES
January 1st, 1953 to December 31st, 1953
(Prepared from Records after Partial Audit)

RECEIPTS										EXPENDITURES										BALANCES—DECEMBER 31ST, 1953 REPRESENTED BY											
FUND	BALANCES JANUARY 1ST, 1953			Interest on Savings Accounts		Income from Investments		Transfer from Nellie N. Cowles Income Fund		SUB-TOTAL		Special Purposes		Library Purposes		General Purposes		Transfers to General Fund		BALANCES 31ST, 1953		Savings Accounts		Investments		Additions		Inter-Fund Transfers		Deductions	
				Per Cent	Amount	Cakes	Sale of																								
Baker.....	\$97.52	\$.90	.47		\$45.89	—	—	—	\$144.31	—	—	—	\$125.36	—	—	—	—	—	—	\$18.95	\$7.74	—	—	—	—	\$11.21	—	—	—	—	\$18.95
Barker, Lewellys F.....	121.25	1.50	.31		30.27	—	—	—	153.02	—	—	—	89.10	—	—	—	—	—	—	63.92	72.92	—	—	—	—	7.40	—	—	—	—	63.92
Barker, Josiah S.....	741.76	17.00	6.85		668.91	—	—	—	1,427.67	—	—	—	—	—	\$323.00	—	—	—	—	1,104.67	941.18	—	—	—	—	163.49	—	—	—	—	1,104.67
Bressler, Frank C.....	185.12	2.60	1.44		140.62	—	—	—	328.34	—	—	—	—	—	—	—	—	—	—	328.34	293.97	—	—	—	—	34.37	—	—	—	—	328.34
Cordell, Eugene	4,871.30	30.00	3.03		295.89	—	—	—	5,197.19	—	—	—	—	—	—	—	—	—	—	5,197.19	997.80	—	—	—	—	72.32	—	—	—	—	5,197.19
Fauntleroy.....	—	—	—		—	—	—	\$31.11	31.11	—	—	—	—	—	—	—	—	—	—	31.11	—	—	—	—	—	—	—	—	—	—	31.11
Cowles, Nellie N.....	—	—	—		1,072.21	—	—	—	1,072.21	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	262.07	—	—	—	—	262.07
Ellis, Charles M.....	1,411.94	18.35	6.79		646.64	—	—	—	2,076.93	—	—	—	853.78	—	—	—	—	—	—	1,223.15	1,077.50	—	—	—	—	162.05	—	\$16.40	—	—	1,223.15
Finney, John M. T.....	2,984.23	29.35	11.74		1,161.44	—	—	—	4,175.02	—	—	—	3,227.19	—	—	—	—	—	—	947.83	652.62	—	—	—	—	280.21	\$15.00	—	—	—	947.83
Frick, William F.....	115.75	1.50	.59		57.60	—	—	—	174.85	—	—	—	—	—	—	—	—	—	—	174.85	160.78	—	—	—	—	14.07	—	—	—	—	174.85
Friedenwald, Julius ..	118.93	1.45	.66		64.45	—	—	—	184.83	—	—	—	160.90	—	—	—	—	—	—	23.93	8.18	—	—	—	—	15.75	—	—	—	—	23.93
Harlan, Herbert.....	129.53	1.45	.62		48.47	—	—	—	179.45	—	—	—	68.20	—	—	—	—	—	—	111.25	108.52	—	—	—	—	14.79	—	12.06	—	—	111.25
McCleary, Standish....	729.64	10.65	1.11		108.39	—	—	—	848.68	—	—	—	—	—	58.00	—	—	—	—	790.68	764.19	—	—	—	—	26.49	—	—	—	—	790.68
Osler Endowment.....	1,173.32	16.60	6.78		692.67	—	—	—	1,882.59	—	—	—	627.84	—	—	—	—	—	—	1,254.75	1,062.33	—	—	—	—	161.82	30.60	—	—	—	1,254.75
Osler Testimonial.....	10,851.52	30.00	41.31		4,033.99	\$2.40	—	—	14,917.91	—	—	—	2,707.93	—	—	—	—	—	—	11,909.98	5,865.09	—	—	—	—	994.89	—	—	—	—	11,909.98
Rubrah, John.....	2,054.41	24.25	3.46		320.73	—	—	—	2,399.39	—	—	—	578.55	—	—	—	—	—	—	1,820.84	1,773.48	—	—	—	—	82.58	—	17.14	18.08	—	1,820.84
Stokes, William Royal	—	—	—		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Trimble, Isaac	704.00	10.10	2.10		205.08	—	—	—	919.18	\$141.76	—	—	—	—	—	—	—	—	—	777.42	727.30	—	—	—	—	50.12	—	—	—	—	777.42
Ridgeway.....	357.97	5.05	1.76		171.93	—	—	—	534.95	—	—	—	—	—	—	—	—	—	—	534.95	492.88	—	—	—	—	42.07	—	—	—	—	534.95
Woods, Hiram.....	—	—	—		—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Totals.....	26,648.19	200.75	100.00		9,765.18	2.40	—	31.11	36,647.63	141.76	—	—	8,438.85	—	—	—	381.00	—	26,313.81	15,037.59	—	—	—	—	9,177.07	45.60	45.60	296.55	26,313.81	—	—

CONSOLIDATED FUNDS—AMOUNTS IN PRINCIPAL FUND

December 31st, 1953

(Prepared from Records after Partial Audit)

FUND	PURPOSE	AMOUNT
Baker.....	Books on Materia Medica.....	\$ 870.50
Barker, Lewellys F.....	Library.....	520.00
Bowen, Josiah S.....	General.....	11,807.29
Bressler, Frank C.....	General.....	2,400.00
Cordell, Eugene Fauntleroy.....	Relief of Widows and Orphans.....	4,847.97
Cowles, Nellie N.....	Library—Exhibit K.....	1,000.00
Ellis, Charles M.....	General.....	6,000.00
Finney, John M. T.....	Books, Journals and Lectureships on Surgery.....	11,181.32
Frick, William F.....	Maintenance Frick Library, Purchase Books and Journals.....	20,000.00
Friedenwald, Julius.....	Maintenance of Friedenwald Room.....	1,000.00
Harlan, Herbert.....	Books on Ophthalmology.....	1,015.00
McCleary, Standish.....	Lectureships and Books on Pathology.....	1,000.00
Osler Endowment.....	Permanent Endowment for Books and Buildings, by Request of Dr. Osler... ..	1,860.98
Osler Testimonial.....	Medical Books and Maintenance of Osler Hall.....	10,316.99
Ruhräh, John.....	Library, Books and Journals, etc.....	54,317.86
Stokes, William Royal.....	Lectureships and Books on Bacteriology.....	4,119.59
Trimble, Isaac Ridgeway.....	Lectureships Only.....	3,519.25
Woods, Hiram.....	General.....	3,000.00
Total—to Exhibit A.....		<u>138,776.75</u>

FUNDS INVESTED IN FIXED ASSETS—PRINCIPAL

December 31st, 1953

(Prepared from Records after Partial Audit)

January 1st, 1953—Balance to Credit of Account.....		\$393,946.46
<i>Additions</i>		
January 23rd, 1953—One Bracket Mahogany Board Sign with Gold Leaf Lettering for Office.....	\$ 55.00	
February 6th, 1953—One Gray Steel Four Drawer Letter File.....	83.50	
May 11th, 1953—Four New Window Shades.....	31.60	
June 4th, 1953—One Paymaster Check Protector.....	45.00	
October 19th, 1953—Two Underwood Standard Typewriters.....	295.00	
December 16th, 1953—One Gray Steel Storage Cabinet.....	55.44	565.54
December 31st, 1953—Balance to Credit of Account—to Exhibit A.....		<u>394,512.00</u>

BUILDING FUND—PRINCIPAL

January 1st, 1953 to December 31st, 1953

(Prepared from Records after Partial Audit)

January 1st, 1953—Balance to Credit of Account.....		\$60,152.05
<i>Additions</i>		
Payments on Pledges.....	\$2,243.02	
Contribution—Women’s Auxiliary of The Baltimore City Medical Society.....	500.00	
Interest—United States Government Bonds.....	1,100.00	3,843.02
		<u>63,995.07</u>
<i>Deductions</i>		
Bond Premium.....	12.50	
Office Stationery.....	5.10	
Audit Fee.....	268.25	
Capital Expenditures—New Office—Air Conditioner, Radiator, Painting and Electrical Fixtures..	3,056.73	3,342.58
December 31st, 1953—Balance to Credit of Account—to Exhibit A.....		<u>60,652.49</u>

CONTINGENT FUND

January 1st, 1953 to December 31st, 1953
(Prepared from Records after Partial Audit)

INCOME

January 1st, 1953—Balance to Credit of Account.....	\$	527.65	
<i>Additions</i>			
Dividends.....	\$231.00		
Interest—United States Government Bonds.....	125.00		
—Savings Account.....	8.60	364.60	
			892.25
<i>Deductions</i>			
Agency Fee.....			25.00
December 31st, 1953—Balance to Credit of Account—to Exhibit A.....			<u>867.25</u>

PRINCIPAL

January 1st, 1953—Balance to Credit of Account.....	10,012.05		
<i>Deductions</i>			
Agency Fee.....	5.79		
Refund of Amounts Contributed by Employees towards Retirement.....	480.34	486.13	
December 31st, 1953—Balance to Credit of Account—to Exhibit A.....			<u>9,525.92</u>

NELLIE N. COWLES BEQUEST FUND

January 1st, 1953 to December 31st, 1953
(Prepared from Records after Partial Audit)

INCOME

January 1st, 1953—Balance to Credit of Account.....	\$	47.50	
<i>Addition</i>			
Interest—United States Government Bonds.....			25.00
			<u>72.50</u>
<i>Deductions</i>			
Agency Fee.....	\$ 1.25		
Expenditures for Library Purposes.....	40.14		
Transferred to Consolidated Funds—Income Funds—to Exhibits E and F.....	31.11	72.50	
December 31st, 1953—Balance to Credit of Account.....			<u>None</u>

PRINCIPAL

January 1st, 1953—Balance to Credit of Account.....	1,000.00		
<i>Deduction</i>			
Transferred to Consolidated Fund—Principal Funds—Exhibit G.....		1,000.00	
December 31st, 1953—Balance to Credit of Account.....			<u>None</u>

MEDICAL ANNALS FUND

January 1st, 1953 to December 31st, 1953

(Prepared from Records after Partial Audit)

January 1st, 1953—Balance to Credit of Account..... \$781.93

Additions

Interest on Savings Account.....	\$ 7.80	
Receipts from Sale of Annals.....	23.00	30.80

December 31st, 1953—Balance to Credit of Account—to Exhibit A..... 812.73

HARVEY G. BECK LECTURESHIP FUND

January 1st, 1953 to December 31st, 1953

(Prepared from Records after Partial Audit)

INCOME

January 1st, 1953—Balance to Credit of Account..... None

Additions

Dividends.....	\$87.75	
Interest—Savings Account.....	.15	\$ 87.90

87.90

Deduction

Agency Fee..... 4.39

December 31st, 1953—Balance to Credit of Account—to Exhibit A..... 83.51

PRINCIPAL

January 1st, 1953—Balance to Credit of Account..... 1,998.55

No changes during year.....

December 31st, 1953—Balance to Credit of Account—to Exhibit A..... 1,998.55

(Prepared from Records after Partial Audit)

LIABILITIES AND FUNDS

ASSETS		LIABILITIES AND FUNDS	
General Funds		General Funds	
Cash—Maryland Trust Company.....	\$11,418.26	Liabilities	
—Undeposited Receipts.....	1,902.40	Designated Funds	
—Petty Cash Fund.....	100.00	For Library Account—Books and Journals.....	\$40.24
	\$13,420.66	For Geriatrics Committee.....	165.00
			\$205.24
Due from Consolidated Fund—Income Funds		Withholding Tax—December, 1953.....	606.50
Levellys F. Barker Fund.....	16.40	Notes Payable—Maryland Trust Company—due on demand—Interest at 3½% per annum (Certain Securities of Consolidated Fund held as Collateral—See Letter).....	6,000.00
William Royal Stokes Fund.....	18.08	Accrued Interest Payable.....	53.67
Charles M. Ellis Fund.....	262.07	Prepaid 1954 American Medical Association Dues	25.00
Special Savings Account.....	1.00	Prepaid Exhibit Fees.....	150.00
	297.55		
Deferred		Total General Fund Liabilities.....	7,040.41
Dental Books Expense.....	2.38	General Fund Surplus—Exhibit C.....	6,680.18
			\$13,720.59
Total General Fund Assets	\$13,720.59	Total General Fund Liabilities and Surplus.....	\$13,720.59
Consolidated Fund—Income Funds		Consolidated Fund—Income Funds	
Cash—Maryland Trust Company—Exhibit F.....	15,037.59	Liabilities	
—Undeposited Receipts—Exhibit F.....	2,395.70	Due to General Fund—From Levellys F. Barker Fund.....	16.40
—Maryland Trust Company—Special Account.....	1.30	—From William Royal Stokes Fund.....	18.08
	17,434.59	—From Charles M. Ellis Fund.....	262.07
Investments—Exhibit F		—From Special Savings Account.....	1.00
Maryland Medical Service, Inc.....	5,050.00		
Common Stocks.....	4,127.07	Total Consolidated Fund—Income Funds—Liabilities	297.55
	9,177.07	Undistributed Income.....	30
		Consolidated Fund—Income Funds—Balance—Exhibit E.....	26,313.81
Total Consolidated Fund—Income Funds—Assets.....	26,611.66		
Consolidated Fund—Principal		Total Consolidated Fund—Income Funds Liabilities and Balance.....	26,611.66
Uninvested Cash—Held by Maryland Trust Company.....	316.36	Consolidated Fund—Principal	
—Held by Mercantile—Safe Deposit and Trust Company.....	64.46	Designated Funds—Exhibit G.....	138,776.75
Investments (Market Value as of January 1st, 1946 and additions at cost)	380.82		
United States Government and Municipal Bonds.....	39,040.85		
Public Utility and Railroad Bonds.....	20,351.36		
Preferred Stocks.....	10,446.75		
Common Stocks.....	107,915.63		
	177,754.59		
Less—Reserve to bring Book Value of Securities down to Actual Cost.	39,358.66		
Total Consolidated Fund—Principal—Assets.....	138,395.93		
	138,776.75	Total Consolidated Fund—Principal.....	138,776.75
Forwarded.....	179,109.00	Forwarded.....	179,109.00

ASSETS—Continued

Brought Forward.....	\$179,109.00
Funds Invested in Fixed Assets (No Depreciation Provided)	
Real Estate—Cost	
Property 1209-11-13 Cathedral Street— In Fee.....	\$110,635.76
Annex Property—1215-17 Cathedral Street—In Fee.....	19,118.95 \$129,754.71
Personal Property—Appraisal Figures at December 31st, 1949 and additions at cost	
Library Books and Journals.....	231,370.00
Office, Library, Household Fixtures, An- tiques and Museum Pieces.....	19,387.29
Portraits.....	14,000.00 264,757.29
Total Funds Invested in Fixed Assets.....	394,512.00
Building Fund	
Cash—First National Bank—Checking Ac- count.....	1,230.15
—Savings Ac- count.....	66.04 1,296.19
Investments—Cost	
United States Government Bonds.....	59,356.30
Total Building Fund Assets.....	60,652.49
Contingent Fund—Income	
Cash—Maryland Trust Company.....	386.91
Due from Contingent Fund—Principal.....	480.34
Total Contingent Fund—Income Assets.....	867.25
Contingent Fund—Principal	
Uninvested Cash—Maryland Trust Company.....	84.96
Investments—Cost	
United States Government Bonds.....	5,000.00
Common Stock.....	4,921.30 9,921.30
Total Contingent Fund—Principal—Assets.....	10,006.26
Medical Annals Fund	
Cash—Union Trust Company of Maryland.....	812.73
Total Medical Annals Fund Assets.....	812.73
Harvey G. Beck Lectureship Fund—Income	
Cash—Maryland Trust Company.....	83.51
Total Harvey G. Beck Lectureship Fund—Income Assets.....	83.51
Harvey G. Beck Lectureship Fund—Principal	
Investments—Cost.....	1,998.55
Common Stock.....	
Total Harvey G. Beck Lectureship Fund—Principal—Assets.....	1,998.55
Total Assets.....	648,041.79

LIABILITIES AND FUNDS—Continued

Brought Forward.....	\$179,109.00
Funds Invested in Fixed Assets	
Principal—Exhibit H.....	\$394,512.00
Total Funds Invested in Fixed Assets—Principal.....	394,512.00
Building Fund	
Principal—Exhibit I.....	60,652.49
Total Building Fund—Principal.....	60,652.49
Contingent Fund—Income	
Balance—Exhibit J.....	867.25
Total Contingent Fund—Income Balance.....	867.25
Contingent Fund—Principal	
Liabilities	
Due to Contingent Fund—Income.....	480.34
Total Contingent Fund—Principal—Liabili- ties.....	480.34
Contingent Fund—Principal—Exhibit J.....	9,525.92
Total Contingent Fund—Principal—Liabilities and Principal.....	10,006.26
Medical Annals Fund	
Principal—Exhibit L.....	812.73
Total Medical Annals Fund—Principal.....	812.73
Harvey G. Beck Lectureship Fund—Income	
Balance—Exhibit M.....	83.51
Total Harvey G. Beck Lectureship Fund—Income Balance.....	83.51
Harvey G. Beck Lectureship Fund—Principal	
Principal—Exhibit M.....	1,998.55
Total Harvey G. Beck Lectureship Fund—Principal.....	1,998.55
Total Liabilities and Funds.....	648,041.79

CERTIFICATE

THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND,
1211 CATHEDRAL STREET,
BALTIMORE 1, MARYLAND.

GENTLEMEN:

We have made a partial audit of the records in the office of the Treasurer of The Medical and Chirurgical Faculty of the State of Maryland for the year ended December 31st, 1953. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances, with the exception of the verification of membership dues.

In our opinion, the Exhibits, together with the comments in this report, present fairly the financial position of the Faculty as of December 31st, 1953, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Respectfully submitted,
WOODEN, BENSON & WALTON
*Certified Public Accountants,
Members American Institute of
Accountants*

FISCAL FACTS*
of the
Medical and Chirurgical Faculty
of the State of Maryland.

Being a re-cast of the Budget for the 1954 Fiscal Year

Estimated Income—Fiscal Year, 1954—by Source			Meetings, Annual and Semi-annual**		7,500.00 or 6%	
From Dues	\$ 83,413.00	66.7%	Office Supplies, office equipment and printing		6,188.00 or	4.9%
From Journal advertising	17,358.00	13.9%	Miscellaneous		4,607.00 or	3.8%
From Invested Funds	9,136.00	7.3%	Other:			
From Annual and Semi-annual Meetings	5,401.00	4.3%	Legal fees		\$ 851.00	
From Baltimore City Medical Society and Dental Society	4,907.00	4%	Taxes		2,020.00	
From Rentals	4,785.00	3.8%	Travel		1,500.00	
			Service to Committees		1,500.00	5,871.00 or 4.7%
	\$125,000.00	100.0%			\$125,000.00	100.0%
MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND			Cost of Journal		\$23,544.00	
			Less Revenue from Advertising		17,358.00	
					6,186.00	
Estimated Disbursements—Fiscal Year, 1954—by Function and Object			Cost of Transactions (formerly separately printed, now published in Journal)		800.00	
Administrative, secretarial and clerical salaries	\$ 35,273.00 or	28.2%			5,386.00	
Publication of Journal*	23,544.00 or	18.9%				
Maintenance of Library	17,577.00 or	14%				
Maintenance of Property	16,340.00 or	13%				
Postage, telephone, light and heat	8,100.00 or	6.5%	Cost per member (2,450 members)		2.20	

* Printed in leaflet form and mailed to all members in April 1954.

** Of this amount \$5,401.00 is collected from sale of exhibit space and from other sources leaving net cost to the Faculty of \$2,099.00 for Annual and Semi-Annual meetings.

COUNCIL*

Mr. President and Members of the House of Delegates:

Since my report, which covered through March 1953, to this body last April, the Council has met six times—April 27, 28, June 12, September 24, October 6 and December 1, 1953. In the interim of Council meetings, the Executive Committee, either by correspondence or telephone, took care of matters regarding the Faculty.

The Board of Medical Examiners, through its officers, Doctors E. H. Kroman and Lewis P. Gundry, discussed Board problems with the Council. These were in reference to naturopaths, qualifications for licensure of graduates of foreign medical schools.

The Study of the Commission on Chronic Illness, which is to include the necessity of hospital care, home care, rehabilitation, nursing home care, and domiciliary care was presented to the Council by Dr. Dean Roberts. This study was approved in principal by the Council and the Editor of the Maryland State Medical Journal was authorized to publish appropriate information in the Journal. (Published in June 1953 issue.)

Committees regarding the following were appointed by the Council: Committee to make a study of the resolution in reference to recent rulings developed by the Advisory Committee on Internships to the Council on Medical Education and Hospitals of the American Medical Association. This Committee reported its findings.

At the request of the American Medical Association, a Committee on Veterans' Medical Care was appointed. (Ratified by the House of Delegates, October 6, 1953.)

On recommendation of Dr. E. Cowles Andrus, the Council approved the appointment of a Budget Committee.

The following having completed fifty years of active membership, will in conformity with the Constitution and By-Laws, now be carried as full active members without payment of dues:

Dr. J. Albert Chatard, Baltimore
 Dr. William H. Coulbourn, Crisfield
 Dr. John E. Legge, Baltimore
 Dr. Victor D. Miller, Hagerstown
 Dr. Irving J. Spear, Baltimore

Dr. Chatard stated that he appreciated the honor, but intended to continue paying his dues.

Library Reports were submitted to Council periodically and in most instances these were approved, and have been put into effect in the Library.

The Library Committee recommended discontinuing having the Library open in the evening. The Council concurred, and the Library will be open on Monday, Wednesday and Friday, from 9:00 a.m. to 6:00 p.m.

On recommendation of the Library Committee, the Council approved of selling Cordell's Annals for two dollars (\$2.00), instead of the previous price of five dollars (\$5.00) per volume.

* Council report for 1953 made by Dr. C. Reid Edwards, whose term expired December 31, 1953. Report for January 1954 through March 1954 made by Dr. E. Cowles Andrus, and there may be some overlapping in both of these reports.

The Council recommended to the Health Department of the State of Maryland that Dr. James T. Marsh and Dr. Page C. Jett be reappointed on the Council on Medical Care Program of the State Department of Health.

The following appointments were made by authority vested in the Council:

- a. Names submitted to the Governor for appointment to the Medical Board for Occupational Disease for State Industrial Accident Commission—Dr. W. K. Waller, Dr. N. B. Herman, Dr. J. S. Eastland, and Dr. Whitmer B. Firor. At the time of the first vacancy, the Governor appointed Dr. James Frenkil. Later when there were two vacancies, from the latter three names listed, the Governor appointed Dr. Eastland and Dr. Firor.
- b. Names submitted to the Governor for appointment on the Advisory Council on Hospital Construction to the State of Maryland—Dr. W. D. Wise, Dr. T. K. Galvin, and Dr. Samuel McLanahan. Dr. Wise was appointed.
- c. Names submitted to the Governor for appointment on the State Board of Physical Therapy Examiners—Dr. H. A. Jones, Dr. A. F. Voshell, and Dr. R. E. Lenhard. Dr. Jones was appointed.
- d. Dr. A. M. Chesney appointed as additional representative (Dr. J. A. Chatard has been the only representative) of the Faculty on the Coordinating Council for Fund Raising Campaigns of the Association of Commerce.
- e. Committee on Increase in Dues appointed by the President of the Faculty—Dr. W. O. McLane, Chairman, Dr. C. W. Mitchell, Dr. N. E. Sartorius, Jr., Dr. W. Kenneth Mansfield and Dr. H. F. Klinefelter, Jr.
- f. Committee appointed by the Chairman of the Council to make a study and recommendations to the Council on a resolution from the Blair County Medical Society concerning approval of hospitals for internships—Dr. C. L. Conley, Chairman, Dr. C. H. Conley, Dr. E. I. Cornbrooks, Jr., Dr. D. J. Gilmore, Dr. L. P. Gundry, Dr. J. H. Hornbaker, Dr. N. J. Kohlerman, Dr. J. F. Supplee and Dr. H. E. Wilgis.
- g. Committee appointed by the President of the Faculty to appoint a Committee to nominate a candidate for the 1953 award of the "President's Committee on National Employ the Physically Handicapped Week"—Dr. N. B. Herman, Chairman, Dr. Herman Seidel and Dr. Dean W. Roberts.

Other American Medical Association suggestions and recommendations in regard to the following were discussed by the Council and specific action was taken on some of the subjects:

The Bureau of Health Education asked that a representative be appointed to attend the Fourth National Conference on Physicians and Schools (Dr. D. C. Wharton Smith).

The Bricker Amendment (June 12, 1953 and February 9, 1954)—VA Hospitalization Rider.

Letter from Committee on Mental Hygiene of the American Medical Association referred to the Faculty's Committee on Mental Hygiene.

Several Societies—Dental, Dental Assistants, Arthritis and

Rheumatism Foundation, and Medical Society for Medical Research—asked permission to hold meetings in the Faculty Building, and as these groups are allied to medicine, the Council approved with the provision that the specific group reimburse the janitorial staff who had to be on duty for these meetings.

In conformity with the American Medical Association ruling, the Council also ruled that physicians who are members of the U.S. Public Health Service will not be excused from the payment of Faculty dues. This ruling is in view of the fact that those in U.S. Public Health Service are not classified as a part of the Armed Forces. Later the American Medical Association changed its policy regarding the status of these physicians and excused them from the payment of dues, but Council reaffirmed its policy.

The Council approved the development of a panel of expert witnesses. As Chairman of the Council, I met on several occasions with members of the Bar Association and a secret committee of members of the Faculty has been appointed to this very important project of our Faculty.

The Council ratified the action of the Executive Committee in complying with the request from Cornell University with reference to an Automobile Crash Injury Research Study.

Dr. Beverley C. Compton, Chairman of the Committee on Scientific Work and Arrangements, was authorized to develop supplemental committees and such assistance as deemed requisite.

The Committee appointed by the Council reported that Dr. George E. Bennett was selected for nomination for the "Physicians' Award," which is given by "The President's Committee on National Employ the Physically Handicapped Week." Dr. Bennett received a "Merit Award" from Maryland and a citation for outstanding service from "The President's Committee."

Dr. J. A. Chatard, as Treasurer, and Mr. W. N. Kirkman, the Director, reported at several Council meetings on the financial status of the Faculty, so that the Council is always conversant with these problems and took action when necessary.

Mr. Walter N. Kirkman at the December 1953 meeting, announced that on account of his age, within a reasonable time the Council should start looking for his successor, and the Chairman of the Council, as his last duty in this capacity, was authorized to appoint a Committee to make recommendations to the Council regarding a Director.

The Council appointed Dr. William B. Long to the Editorial Board of the Maryland State Medical Journal to fill the vacancy due to Dr. J. Tyler Baker having gone into Military Service.

The Council authorized lending museum material to the Maryland Historical Society for the Exhibit on the History of Medicine in Maryland.

The Council approved the appropriation of \$35.00 per year per American Medical Association delegate for the Aces and Deuces organization.

The Council discussed the request from the Maryland Academy of General Practice suggesting that the Council select membership from the Academy to serve on the Boards of the Maryland Hospital Service, Inc., and the Maryland

Medical Service, Inc. The Council believed that its responsibility is to the medical profession at large, and feels that the present method of selecting appointees not be changed.

The Council concurred in the requests of the Committee on Scientific Work and Arrangements regarding the Annual Meeting, and the business sessions so far as is possible will be held on Monday, April 26, 1954, and the Round Table Luncheon feature is to be resumed.

An abstract from the Resolution forwarded through the House of Delegates to the Council, from the Committee to Study Legislative and Professional Standards and Staff Relations, was read to the Council. This Resolution requests that the State Licensure Law be changed, in that the State Department of Health be requested to obtain the services of a Special Advisory Committee, made up of elected and appointed members of the Medical and Chirurgical Faculty. Dr. Pincoffs stated that he does not believe that the Board of Health would, or should, rule on Hospital Staff appointments, and that this Society is opposed to the recommendation presented in this Resolution. This was seconded and carried.

Dr. E. Cowles Andrus was elected Chairman of the Council for 1954, and Dr. Whitmer B. Firor was elected as the Vice-Chairman for the coming year.

The Council expressed its appreciation to Dr. Edwards, whose term as Chairman expires and to Dr. Yeager, whose term as Secretary terminates.

Respectfully submitted,

C. REID EDWARDS, M.D., *Chairman, 1953*

* * * * *

Mr. President and Members of the House of Delegates:

There have been three meetings of the Council and two of the Executive Committee between January 1, 1954, and April 14, 1954.

The Executive Committee plans to meet in the interim and prior to the meetings of Council to review the material that is in hand and whenever possible either to have recommendations ready for Council or to take action on subjects that are within its scope. In cases that need immediate action the Executive Committee will be canvassed by mail or 'phone. There have been two Council meetings and two Executive Committee meetings in 1954, at the time this report is being written.

At the December meeting of the Council, representatives from the Maryland Society of Pathologists discussed a proposed law, to which that Society is opposed, on "State Licensure of Laboratory Workers." As authorized by the Council, the Executive Committee subsequently met with Dr. C. A. Perry, Chief, Bureau of Laboratories of the State Department of Health, who is interested in a licensing agency in Maryland for laboratory workers. Dr. Perry explained that there would be no infringement of the Medical Practice Act to be expected as a result of the licensure of laboratory technicians. No action was taken as Dr. Perry did not have the proposed law ready, and Mr. Anderson, the Attorney for the Faculty, cannot give the Council any definite advice until a copy of the proposed legislation is available. (This has recently come to hand, has been referred to Mr.

Anderson, and will be distributed to the Officers of the Component Medical Societies and to the Council.)

The Council approved the buying of new chairs for Osler Hall.

The outline for the business sessions of the 1954 Annual Meeting, as presented by Dr. A. A. Pearre, for the Committee on Constitution and By-Laws was approved by the Council.

The Council granted the request of Mrs. John G. Ball that a symbol be used on the membership roster that indicates that the doctor's wife is a member of the Woman's Auxiliary.

The Budget, as presented by Dr. Chatard and Mr. Kirkman, was approved.

Three additional stenographers are to be employed; one of these is to be assigned to the Maryland State Medical Journal, and the others to assist with the secretarial work of the office.

The Secretary, Dr. Diggs, was authorized to arrange a luncheon discussion meeting for the Secretaries of the Component Societies.

All legislative matters, whether at the State or Federal level, are to be referred to the Legislative Committee.

Legislative matters regarding homeopathy being deleted from the Medical Practice Act, Bricker Amendment, Chiroprody, central location for licensing boards, abolishment of the Occupational Disease Board, were discussed and Dr. Mech and Mr. Kirkman were instructed as to the wishes of the Council.

Dr. Robert H. Riley, Director of the Maryland State Health Department, asked for cooperation and assistance of the practicing physicians in the field trial of poliomyelitis vaccine in one of the Maryland counties.

This request was approved in principal and the Newspaper release (with some alterations), requested by the Health Department, was approved.

Requests from some of the Component Societies were presented for action.

Library requests were submitted, discussed and Dr. Krause, the Chairman of the Library Committee, was advised according to Council action in each matter.

The Council acceded to the request of Dr. Chatard. The Chairman was authorized to appoint an Assistant Treasurer, and Dr. Wetherbee Fort has been asked to serve in this capacity.

Providing the members of the Faculty indicate they would be interested in supporting a Postgraduate Day, the President of the Faculty will appoint a committee to arrange the program. Immediately after the Annual Meeting, the members will be canvassed and every member is urged to answer and return the card.

The Council approved the recommendation of the President, Dr. Kneisley, and the following Committees were discharged:

- 1) Committee to Study Legislative and Professional Standards and Staff Relations of Hospitals.
- 2) Committee to Study an Insurance Problem.

It was recommended to Dr. A. E. Goldstein, Chairman of the Subcommittee on Finance for the New Building, that he present his resolution regarding the Building Fund to the Resolutions Committee for the House of Delegates.

There have been eleven members who have been granted

Physicians' Defense and Mr. Anderson reported the settlement of two malpractice cases.

At the September 24th meeting of the Council, Mr. G. C. A. Anderson was unanimously reselected for appointment as legal counsel.

The Council, under the Law, submits names to the Governor and he selects the member to serve on Boards, Councils, etc. In cases where the terms of office expired, Council submitted the requested recommendations. Since January 1, 1954, the following names have been sent to Governor McKeldin:

- a. State Board of Physical Therapy Examiners: Dr. W. Richard Ferguson, Baltimore; Dr. Samuel McLanahan, Baltimore; Dr. Harry F. Klinefelter, Jr., Baltimore.
- b. Advisory Council on Hospital Construction which consults with and advises the State Board of Health: Dr. William D. Noble, Easton; Dr. Richard V. Hauver, Hagerstown; Dr. Waldo B. Moyers, Hyattsville.

The Council recommends the following for Emeritus Membership: (See page 410.)

Dr. Frank J. Ayd, Baltimore
Dr. William A. Bridges, Baltimore County
Dr. E. W. Bridgman, Baltimore
Dr. Norman S. Dudley, Queen Anne's County
Dr. John M. T. Finney, Jr., Baltimore
Dr. Waller E. Grempler, Baltimore
Dr. Eugene H. Hayward, Baltimore
Dr. Kenneth D. Legge, Baltimore
Dr. William B. Schapiro, Baltimore
Dr. Herbert Schoenrich, Baltimore
Dr. Edward P. Smith, Baltimore
Dr. William Kelso White, Baltimore

Respectfully submitted,

E. COWLES ANDRUS, M.D., *Chairman, 1954*

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Mr. President and Members of the House of Delegates:

Your delegate attended the Annual Meeting in New York City from June 1 to June 5, 1953, and also the Interim Session in St. Louis from December 1 to 4, 1953. Both meetings were well attended, particularly the New York City meeting. A point of interest was that Dr. Alfred Blalock of Baltimore was elected recipient of the District Service Award of the A.M.A. for 1953 at the New York meeting.

As usual, a large volume of business was done at the annual meeting. The proceedings are recorded in the Journal of the A.M.A. on the dates of June 20 and June 27, 1953. It is to be pointed out in these reports that a Study of Relations Between Osteopathy and Medicine created a lot of discussion and it was definitely decided that any action on this lengthy report should be deferred until the Session of June 1954.

The Secretary of the Department of Health, Education and Welfare, Mrs. Oveta Culp Hobby, outlined the present Administration's ideas on Medicine without being at all specific except that she endeavored to assure the delegates that changes had to be made to meet the present socio-economic

problems but should be done under the private and voluntary system with some Federal aid where needed.

The Principles of Medical Ethics again came up for discussion but no specific changes were made, the provisions being more or less general in nature.

The Council on Constitution and By-laws was urged to revise these principles in an effort to meet the problems that arise in various sections of the country.

The Council on Medical Education and Hospitals gave an elaborate report which came under some criticism, particularly in regard to the "Essentials of an Approved Internship." This matter was left over, to be acted upon at the Interim Meeting in December.

Many other resolutions were made and referred to the various Reference Committees but these are too numerous to mention.

The elections, of course, were held at this meeting and Dr. Walter B. Martin of Norfolk, became President elect and Dr. Edward J. McCormick of Toledo, Ohio, became President for the ensuing year.

The Seventh Annual Clinical meeting took place in St. Louis in December 1953. Your delegate was on the Reference Committee for Medical Education and Hospitals. This Committee had many matters referred to it and he did not have the opportunity to attend other Reference Committee meetings.

One of the high lights of the meeting was the address by Dr. Chester Keeffer of Boston who is Special Assistant to Mrs. Hobby. He emphasized, "The voluntary way has been the most successful in the past and there is no reason to believe it will not continue to be in the future." He urged maximum effort, cooperation and leadership on the community level. The House of Delegates reaffirmed its opposition to the compulsory coverage of physicians under the Old Age and Survivors Provision of the Social Security Act and advocated passage of the Jenkins-Keogh Bill. These bills are described as providing for the establishment of a voluntary pension program.

The Bricker Amendment was approved in principle. This is a very controversial point and the A.M.A. attitude is that no agreement should be reached with foreign countries that might encroach upon voluntary medical care.

The House opposed any further extension of the Doctor Draft Law beyond the present expiration date of June 30, 1955.

The House approved the revision of one section of the Principles of Medical Ethics which clarifies the relationship of physicians to all forms of public information media. It would be well for all members to read this.

In the Reference Committee on Medical Education and Hospitals there was a great deal of discussion regarding the rules and regulations of the Joint Commission on Accreditation of Hospitals. This Committee requested that the Joint Commission publish an article or series of articles in the Journal of the A.M.A. and other official publications to acquaint the medical and hospital profession with the regulations, by-laws and their interpretations.

Finally, Dr. McCormick in his President's address made a

strong appeal to the nation's physicians for "action that will further the full confidence of the public in our profession."

Respectfully submitted,
WARDE B. ALLAN, M.D.

DELEGATE TO THE AMERICAN MEDICAL ASSOCIATION

Mr. President and Members of the House of Delegates:

As your Delegate to the American Medical Association in 1953, I attended the meetings of the House of Delegates in New York in June, and at St. Louis in December. I also attended a special meeting of the House in March at Washington, to hear President Eisenhower and the late Senator Taft discuss the administration's attitude toward Government in Medicine and the plans for the Department of Health, Education and Welfare which had been activated only a few weeks previously. In addition to the above meetings, I attended a regional meeting of the Council on Medical Service, at Washington, to discuss the problems of Veteran's care.

At the New York meeting Veteran's Care was extensively debated, the House reaffirming its previous stand, expressing disfavor that hospitalization be offered for any non-service connected disability other than tuberculosis, psychiatric or neurological disorders. The House deferred action until further study, on a resolution to permit physicians to teach in osteopathic schools and to consult with osteopaths, a measure which has been much discussed in recent AMA meetings. The House passed a resolution in favor of the "Bricker" bill which seems to have died in Congress but which may be expected to crop up again. The feeling is prevalent in the House that health plans incorporated into treaties may result in government interference with the practice of medicine.

At the St. Louis meeting in December, the matter of relationships with osteopaths and their schools was again brought up, this time in regard to the quality of teaching in those schools. The matter was referred to the Board of Trustees with the recommendation that a board be established to inquire into the schools of osteopathy so that they can be properly judged. The resolutions in regard to the use of the term "rehabilitation" were referred to the Board of Trustees for further analysis after consulting with the orthopedists and other specialists concerned. A resolution asking that the "matching plan" for selection of interns was disapproved. The House approved the recommendation that the Association support legislative action to permit tax deferments for self-employed persons entering voluntary pension plans and to oppose extension of compulsory enrollment in Social Security.

The regional meeting to discuss Veteran's Hospital matters in November was concerned with methods to implement the above mentioned attitude toward limited hospitalization and resulted in expression of opinion quite similar to the stand taken by this House (Maryland) at its semi-annual meeting in October 1953.

I wish to express my appreciation to this House and to the Faculty for entrusting me with the duties and privileges of

being a Delegate to the American Medical Association during the past three years.

Respectfully submitted,
JOHN W. PARSONS, M.D.

BOARD OF MEDICAL EXAMINERS

Mr. President and Members of the House of Delegates:

The Board of Medical Examiners of Maryland is composed of the following members whose terms expire on the dates indicated:

Lewis P. Gundry	—1954
Edward P. Thomas	—1954
Erasmus H. Kloman	—1955
John H. Hornbaker	—1955
John E. Legge	—1956
Samuel McLanahan	—1956
Henry T. Collenberg	—1957
Norman E. Sartorius, Jr.	—1957

As the terms of Dr. Gundry and Dr. Thomas expire in June 1954, two members to serve until 1958 are to be elected at this meeting of the Medical and Chirurgical Faculty.

Examinations given during the year show the following results:

Applications for examination.....	437
Second year students examined.....	159
Postponed or withdrew.....	23
Not eligible for license.....	182
Examined in second part of examination...	143
Complete examination given.....	112
Eligible for license.....	255

Passed.....	234
Failed.....	21

Sixteen of those who failed were graduates of foreign medical schools, three were graduates of Howard University, and two were graduates of Meharry Medical College.

Licenses issued after examination.....	234
Licenses issued by reciprocity with other States.	104
Licenses issued in recognition of National Board	
Certificates.....	104

Total licenses issued.....	442
Licenses revoked.....	2
License restored.....	1

Certificates of transfer to other States.....	227
Borderline permits to D. C. licentiates.....	49
Copies of license issued.....	6
Foreign graduates approved for examination...	59
Written inquiries from foreign graduates.....	278
Office interviews with foreign graduates (approx.)	250
Telephoned inquiries from foreign graduates— no record kept	
Foreign graduates examined..	40
Passed—foreign.....	24
Failed—foreign.....	16

On May 13, 1953, four members of the Board of Medical

Examiners attended a hearing in the Circuit Court of Prince George's County, to which they had been summoned, on an appeal from a Revocation Order which the Board had entered against a physician who had been convicted of Income Tax evasion. The Court at this hearing held that the Board of Medical Examiners was not legally constituted at the time the revocation order was passed. This opinion was based on the fact that a substitute member had been appointed to serve during the leave of absence of a Board member who was ill.

The Court also ruled that no further hearing could be held in the case while any Board member, who had been present at the original hearing, remained a member of the Board.

Although the Law states that the decision of the Court shall be final in such cases, the Attorney General entered an appeal on the ground that prohibiting the Board from hearing the case again would practically abolish the Board. This decision, it was argued, was not within the authority of the Court. The Court of Appeals upheld the lower Court in the matter of the composition of the Board but reversed the decision with regard to another hearing. Another hearing will be conducted.

David Aitchison, Naturopath

Dr. Gundry appeared for the Board in the Circuit Court of Montgomery County on December 3, 1953, when David Aitchison, a naturopath, was found guilty of four counts of unlawful practice of medicine. The sentences on each of two counts were suspended but fines of \$200.00 and costs were imposed for each of the other two counts, with prison terms if the fines were not paid. Aitchison immediately entered an appeal. This Board has been endeavoring since June 1950 to have this man convicted of illegal practice of medicine or using the mails to practice medicine, but was unsuccessful until this recent conviction.

Naturopaths

In an attempt to prosecute naturopaths who are practicing medicine in Baltimore City, the Board wrote the Police Commissioner on May 27, 1953 asking an investigation of persons listed as naturopaths in the local telephone directory. The Board feels that as Naturopathy has not been recognized in Maryland as a branch of healing, and since the Circuit Court of Baltimore City on March 3, 1948 held that practice of Naturopathy is in violation of the medical practice act, these practitioners should not be permitted to continue their work. After much delay and considerable correspondence, report was received from the Police Department that the persons named had been visited and certain information secured. The information given was the name, school of reported graduation, etc, all of which had been known to the Board of Medical Examiners for sometime. The Board then wrote the Police Department stating that there seemed to be some misunderstandings as to the wishes of this Board and asked that a representative meet with the Secretary of the Board to discuss the matter. Shortly afterward a Lieutenant of the Detective Bureau came to the Board office with several detectives.

These men were instructed to pose as patients and get all evidence possible of the medical work being done. Few days later we received the report that the "plain-clothes" men were unable to obtain any information from the naturopaths, who seemed to have been alerted by the recent previous visits of uniformed police. The Police Department reported that nothing further could be done at the time.

Louis Werner

The State's Attorney of Baltimore City has been asked to take action against one Louis Werner who has been reported as practicing medicine without a license. Dr. Warfield Firor has sent the Board a signed statement of a woman who has been treated by this man for a very serious ailment, as a result of which treatment she was later referred to Dr. Firor. The statement and letter of Dr. Firor were sent to the State's Attorney's office on February 16, 1954.

During the 1954 session of the General Assembly, at the request of the Board of Medical Examiners-Homeopathic, a Bill to abolish that Board was introduced. Since the Medical Practice Act provides for a regular and a Homeopathic Board it would be necessary to amend the Act to delete all references to two Boards. This Board and the Medical Faculty opposed amending the Medical Practice Act at this time. The Bill did not come out of Committee.

An Amendment to the Medical Practice Act to provide for an appeal to the Court of Appeals in cases where an Order of Revocation was not affirmed by a Circuit Court also failed to pass.

Chicago Meeting

Dr. Gundry, Dr. McLanahan and Dr. Kroman attended the Congress on Medical Education and Licensure at Chicago in February 1954, and obtained much valuable information from discussions of licensure problems by members of other State Boards. The reports on methods and results of handling applications from graduates of foreign medical schools were particularly important.

Respectfully submitted,
E. H. KLOMAN, M.D., *Secretary*

April 1, 1954
(See page 412.)

N.B. in re

STATE PRACTICE ACT

State Board of Medical Examiners—Henry T. Collenberg, Wylie M. Faw, Jr., John H. Hornbaker, John E. Legge, Norman E. Sartorius, Jr., Erasmus H. Kroman, President; Samuel McLanahan, Vice-President; Lewis P. Gundry, Secretary, 1215 Cathedral Street, Baltimore 1, Maryland

Meetings of the Board of Medical Examiners of Maryland—The regular annual meeting is held the first Tuesday in June and other meetings are held about four times a year at such times as the discretion of the Board may determine. Special meetings are held from time to time to consider particular policies or problems.

Regular Examinations—Examinations are held in Baltimore, the third Tuesday in June for four consecutive days and the second Tuesday in December for four consecutive days.

Reciprocity or Endorsement Information—The license of the Board of Medical Examiners of Maryland is recognized for license without examination in the following States: Alabama, Arkansas, California, Connecticut, Delaware, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia and Wisconsin.

Many States, however, have special requirements which must be met by each applicant for license by reciprocity or endorsement. For example:

New York requires two years of professional experience, one year of which shall be after obtaining the original license. A grade of at least 75% in each subject except one is also required.

Certain other States require a year of residence in the State granting the original license after the license is issued.

Another State requires a rotating internship before license, or two years of practice after license.

West Virginia requires a baccalaureate degree.

States having Basic Science Laws may require you to take an examination in Basic Sciences. It is well therefore, to write the State in which you are interested, to learn of these particular requirements.

Diplomates of the National Board of Medical Examiners are also admitted to license without examination.

Information connected with Medical Examinations and licensure by addressing the Secretary, 1215 Cathedral Street, Baltimore 1, Maryland.

LIBRARY COMMITTEE AND FINNEY FUND COMMITTEE

Mr. President and Members of the House of Delegates:

The report of the Library Committee probably is best understood by consulting the summary of activities as you will find listed.

I. Services.

a. Reference work (much by telephone)

Supplying names, addresses, etc., of doctors from our directories.

Verifying references, including long bibliographies.

Compiling bibliographies.

Looking up material on hundreds of varied subjects.

Locating specific articles, with little information to go on.

Assembling material for exhibit "300 years of Maryland Medicine."

b. Getting out material for use in library or home use,

checking them in and out and replacing material on shelves.

- c. Mailing material to members throughout the state.
 - d. Preparation of material including checking against card catalog or periodical record for duplication accessioning, classifying and cataloging, etc.
 - e. Borrowing from and lending to other libraries.
 - f. Distributing duplicate books and journals to younger libraries in the city and throughout the world.
 - g. Contributing book lists and library notes for each issue of Maryland State Medical Journal, and compiling indexes to 1952 and 1953 volumes of Journal.
- II. Reorganization.
- a. Reclassification and recataloging of 2,237 volumes, mostly recent books, made them easier to find and put away.
 - b. Open shelves ordered for Reading Room, now in place, making more recent books accessible to readers.
 - c. Glass-doored cases in Reading Room will be used to protect and display valuable old books, now inadequately housed in stacks.
 - d. The Periodical Room and Librarian's Office were air-conditioned.
 - e. Periodical subscriptions have been placed in hands of an agent, in accordance with usual library practice, to save money, time and bookkeeping.
 - f. Visible record equipment purchased to consolidate five former periodical files into one for efficiency.
 - g. Other new equipment purchased: including filing cabinets, book ends, additional book truck, postal scale, bulletin board, etc.
 - h. Space is being made in basement for expansion of periodical collection. With removal of extra copies of Faculty publications for outside storage, this much-needed space has been released.

III. Plans for 1954:

- a. More aggressive policy for purchase of new books.
 - b. Better care of valuable old books and leather bindings.
- While I am writing this report, bear in mind that the work is being done by the Library Staff under the very able leadership of Miss Helen Wheeler, supported by Mrs. Henry Berge, Miss Myrtle Hollins, and Mrs. Ella Chatt.

Respectfully submitted,

LOUIS KRAUSE, M.D., *Chairman, Library Committee* (1955)

JOHN T. KING, M.D. (1954)

A. AUSTIN PEARRE, M.D. (1956)

WILLIAM K. DIEHL, M.D. (1957)

E. T. LISANSKY, M.D. (1958)

MARION W. MCCREA, D.D.S.

Finney Fund Committee

HENRY M. THOMAS, M.D., *Senior Member* (1954)

JOHN M. T. FINNEY, JR., M.D. (1955)

LOUIS P. HAMBURGER, M.D. (1956)

I. RIDGEWAY TRIMBLE, M.D. (1957)

HERBERT E. WILGIS, M.D. (1958)

LIBRARY OF THE MEDICAL AND
CHIRURGICAL FACULTY

GIFTS FOR 1953

Name	Reprints & Misc.	Reports & Pamph.	Bound Jrs.	Jrs.	Books
Abeshouse, B. S.....	8				
Abington Memorial Hospital.....				10	
Acton, Dr. Elizabeth.....				290	
American Cancer Society Inc.....					1
American Cholorophyll Div., Strong Cobb & Co.....		1			
American Clinical & Climatological Assoc.....					1
American Cystoscope Makers, Inc.....					1
American Foundation for the Blind, Inc.....		1			
American Heart Assoc., Inc.....		1			
American Library Assoc.....		1			
American Medical Assoc.....					2
American Neurological Assoc.....					1
Armed Forces Medical Library.....				4	4
Austrian, Dr. C. R.....				104	
Baetjer, Dr. Walter.....					241
Baptisti, Dr. Arthur, Jr.....	6				
Boyd, Dr. Holmes C.....				97	
Brady, Dr. Leo.....				36	3
Brantigan, Dr. Otto.....				158	
Brendle, Dr. William K.....	1				
British Journal of Radiology.....				2	
Cannon, Mr. Burdelle S.....				326	
Charlotte Medical Library.....				10	
Chatard, Dr. J. A.....				89	4
Church Home Hospital.....		1			
Coggins, Dr. Jesse C.....				126	
Columbia University.....	21				
Commissioner of Health of Balti- more.....		1			
Cross, Dr. Ernest S. Jr.....				116	
Cullen, Mrs. Thomas S.....	3			82	7
Cushing, Dr. Mary McKinniss.....	1				
E. I. Du Pont De Nemours & Co., Inc.....	2				
Dunton, Dr. W. R. Jr.....			47	259	2
Edlow, Mrs. E. S.....			8	49	91
Edwards, Dr. Monte.....			17	37	
Enoch Pratt Free Library.....	1				
Feldman, Dr. Maurice.....	1			113	3
Fort, Dr. Wetherbee.....	1			7	3
Friedenwald, Dr. Edgar.....			23		164
Garlick, Dr. Wm. L.....				1	
Gay, Dr. Leslie N.....					3
Geraghty, Dr. F. J.....				56	
Goldman, Dr. Harris.....					13
Goldstein, Dr. A. E.....	3				

LIBRARY GIFTS—Continued

Name	Reprints & Misc.	Reports & Pamph.	Bound Jrs.	Jrs.	Books
Grimson, Dr. Keith S.....	1				
Harvard School of Public Health...	2	1			
Health Information Foundation....					1
Hearn, Mrs. A. C.....			130		
Henry Ford Hospital.....				10	
Hinrichs, Dr. E. H., Jr.....				112	
Hollander, Dr. Mark B.....	1				
Highstein, Dr. Gustav.....					10
Hospital dos Servidores do Estado..				48	
Hospital for the Women of Maryland.....		1			
Howard, Dr. J. T.....				130	
Howe Library of Ophthalmology...					4
Institute of Life Insurance.....		1			
Jackson Co. Med. Soc. Library....					3
Janney, Dr. John H.....	14			17	2
Johns Hopkins Hospital.....		1			
Johns Hopkins University.....		1		3	
Jones, Miss Charlotte A.....					1
Keys, Mr. Thomas E.....	1				
Kirkman, Mr. Walter N.....	1			57	2
Koontz, Dr. Amos R.....			2	387	
Krause, Dr. Louis A. M.....				105	97
Laurel Sanitarium.....				83	
Lederle Laboratories.....					3
Levin, Dr. M. B.....	6				
Lewison, Dr. Edward F.....				173	
Life Insurance Assoc. of America...		1			
J. B. Lippincott Co.....					1
London School of Hygiene and Trop. Med.....				1	
Los Angeles Co. General Hosp....				12	
Louisiana State Dept. of Health..		1			
Louisiana State University.....				15	
M. & R. Laboratories.....		5			
McLanahan, Dr. Samuel.....				313	
McLean, Dr. George.....				343	15
Mahan, Mrs. Archie I.....					4
Macht, David I.....	2				
Josiah Macy, Jr. Foundation.....					1
Mallinckrodt Chemical Works....	2				1
Mansdorfer, Dr. G. B.....				204	
Maryland General Hospital.....				253	
Maryland Historical Society.....			1		
Maryland Tb. Assoc.....					
McGavack, Dr. T. H.....	6				
Medical Soc. of the State of Pa....				108	
Memorial Center for Cancer and Allied Dis.....				10	
Merck & Co. Inc.....					3
Minnesota Department of Health..	2				
Modern Medicine.....					1

LIBRARY GIFTS—Continued

Name	Reprints & Misc.	Reports & Pamph.	Bound Jrs.	Jrs.	Books
Moore, Dr. J. E.....	1569	61		626	6
Morrison, Dr. Samuel.....				1	
Morrison, Dr. Theodore.....				52	
Muscular Dystrophy Assoc. of Amer.....					1
Myers, Dr. J. A.....	31			127	
National Foundation for Infantile Par.....					2
National Medical Fellowships, Inc.....		1			
National Nephrosis Foundation, Inc.....					1
New York Academy of Medicine.....					4
New York State Department of Health.....		1			
Nichols, Dr. E. E.....			116	41	90
Parke, Davis & Co.....					1
Patz, Dr. Arnall.....	2				
Pleasants, Dr. J. Hall.....				17	
Presbyterian Eye, Ear, & Throat Hosp.....		1			
Rienhoff, Dr. Wm. F.....				100	5
Rockefeller Foundation.....	5	1			
Rockefeller Institute for Med. Res.....					2
Rosen, Dr. Harold.....					1
Royal College of Physicians.....					1
St. Joseph's Hospital.....			3	110	47
Seliger, Dr. Robert V., Estate of...	1			12	239
Shannon, Dr. G. E.....					21
Shealy, Dr. Walter H.....				137	
Sheppard Pratt Hosp.....	92			302	1
Sherman, Ruth Brewster.....				20	
Simmons, Dr. James Stevens.....		1			
Skillman, Mrs. W. F.....		1		9	47
Stone, Dr. Harvey.....					3
Sussman, Dr. Abram A.....				87	
Te Linde, Dr. R. W.....					1
Texas Medical Association Lib.....				1	1
Thompson, Dr. Charles B.....					1
Thorek, Dr. Philip.....	12				
Trimble, Dr. I. R.....				79	1
Trott, Miss Bertha M.....				6	
Tulane Univ. School of Med.....			1	53	
U. S. P. H. H. Library.....				2	
Union Carbide and Carbon Corp....		1			
University of Arkansas.....					8
Université Laval Bibliothèque Médicale.....				44	
University of Maryland.....					9
University of Tennessee.....				1	

LIBRARY GIFTS—Concluded

Name	Reprints & Misc.	Reports & Pamph.	Bound Jrs.	Jrs.	Books
University of Texas School of Med.				10	
Washington University School of Med.				10	
Ward, Dr. Grant E.			494		
Wharton, Dr. L. R.			155		
Wikler, Dr. Simon J.					1
Williams, Dr. Huntington		2			
Williams & Wilkins Co.				2	36
Wiscott, W. J.			346		
Wise, Dr. Walter D.			69		
Wollenweber, Dr. Henry L.			210		1
Women's Hospital		1			
Woodruff, Dr. J. D.					19
Yale Med. Library				90	
Yeager, Dr. George H.		16		38	5

LIBRARY REPORT

January to December, 1953

CIRCULATION AND ATTENDANCE

Circulated books	3,623
Books used in Library	3,858
Total	7,481
Total volumes in 1952	76,298
Books added, 1953	676
Journals added, 1953	446

Total volumes in Library	77,420
Attendance	3,118

MEDICAL LIBRARY ASSOCIATION

Issues sent on exchange	2,275
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BINDING

Journals bound	583
Total cost	\$1,843.65
Average cost per journal	\$3.16

COUNTY MEMBERS

Requests filled	239
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GIFTS

Unbound journals	7,608
Bound journals	348
Books	1,248
Reports and Pamphlets	105
Reprints	1,794
Pictures	2

Diplomas	1
Museum pieces (case)	1

Total	11,107
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RECLASSIFICATION AND CATALOGING

Volumes processed	2,237
Volumes withdrawn	12

INTER-LIBRARY LOANS

Loaned

Army Chemical Center	1
Baltimore City Health Dept.	5
Bon Secours Hosp.	1
Ft. Howard Hosp. Lib.	21
Johns Hopkins Univ.	6
Lehigh Univ.	1
Loyola College	2
Medical College of S. C.	1
Mercy Hosp.	2
Notre Dame College	3
Pratt Library	1
St. Joseph's Hosp.	40
Seton Institute	2
Sheppard Pratt Hosp.	13
Sinai Hosp.	31
Social Security Lib.	11
U. S. Army Lib. (Ft. Meade)	2
U. S. Dept. Agriculture	1
U. S. Pub. Health Hosp.	797
U. S. Vet. Admin. Hosp.	1
Univ. Maryland	4
Welch Medical Lib.	74
Wilmer Institute	8

Total	1,028
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Borrowed

Armed Forces Med. Lib.	6
Sheppard Pratt Hosp.	1
U. S. Pub. H. Hosp.	1
Univ. of Maryland	36
Univ. Minn. Farm Lib.	1
Welch Med. Lib.	32
Western Reserve Univ.	1
Wilmer Institute	2

Total	80
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PETTY CASH REPORT

Balance on hand Dec. 31, 1952	\$5.00
Received from office and refunds on express and postage, etc.	156.50

Total	\$161.50
Expenses	136.68

Balance on hand, December 31, 1953	\$24.82
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COMMITTEE ON SCIENTIFIC WORK AND ARRANGEMENTS

Mr. President and Members of the House of Delegates:

The Semiannual Meeting was held in Bethesda, Montgomery County, at the National Institutes of Health, on October 6, 1953. This was the fiftieth anniversary of the Montgomery County Medical Society, and our hosts planned a splendid program with the outstanding feature in the evening of a dinner and dance.

Without the cooperation of the members of the staff of the National Institutes of Health, our members would not have had the opportunity to see and hear the projects of the Institutes, and the Medical and Chirurgical Faculty is deeply appreciative of the assistance rendered by this group.

The local Committee and the ladies, particularly Mrs. Emil G. Bauersfeld, did yeoman work in planning our program, and our Committee wishes to thank them and make this word of appreciation a part of the transactions of the Medical and Chirurgical Faculty.

The program for the 1953 Semiannual Meeting follows this report on page 439.

The program of this year's Annual Meeting also follows this report on page 441.

As I explained in my report last year, it was almost impossible to avoid conflict with National Associations, even though the Committee made every effort to have the meeting on a date when there were no other outstanding scientific assemblies. We find that our meeting is being held at the same time as the American Surgical Association and the American Psychoanalytic Association.

We have resumed the Round Table Luncheon as so many members indicated that they found this a well worthwhile feature, but at the time of the writing of this report, it is too early to ascertain whether or not the attendance will be as great as in previous years. Originally when we held a Round Table Luncheon, those who did not make their reservation early, found that every place was taken, so we had many

disappointed members. This year the Committee has provided approximately twice as many subjects for discussion, anticipating that there will be a larger number of members interested in attending the luncheon and making it so that no one will be disappointed. This year the moderators at each table will be guests of the Society for the first time.

Last year the attendance at the Annual Meeting was 933. This includes the members, their wives, guests, and exhibitors.

The Semiannual Meeting for 1954 will be held in Hagerstown, but the Washington County Medical Society and the Council have not chosen the exact date, but it probably will be in October. An early meeting of this Committee and the County Committee is anticipated.

The Constitution and By-Laws of the Medical and Chirurgical Faculty provides for the election of a Committee on Scientific Work and Arrangements consisting of three members. Our Committee wishes to make a recommendation which may be used for a trial period, and therefore suggests that if this procedure is adopted by the House of Delegates that it be referred to the Nominating Committee to make its selection according to this method. The Committee on Scientific Work and Arrangements recommends that one new member be appointed to it each year, and therefore, each member would serve for a period of three years. After two years of service, the senior member would automatically become the Chairman for a period of one year only, thereby rotating the chairmanship. (See page 411.)

This is my last year as Chairman of the Committee on Scientific Work and Arrangements, and I wish to thank the members of the Medical and Chirurgical Faculty for their kindness and support during my tenure of office, and also to express my appreciation to Mr. Kirkman and all the members of his and our Faculty staff. The work of the latter is more valuable than any words can express.

Respectfully submitted,

BEVERLEY C. COMPTON, M.D., *Chairman*

WILLIAM L. GARLICK, M.D.

EDWIN H. STEWART, JR., M.D.

PROGRAM OF THE SEMIANNUAL MEETING

Tuesday, October 6, 1953

National Institutes of Health, Bethesda, Maryland

Registration—9:00 A.M. and throughout the day, Lobby—Clinical Center Building. (All the members and their guests are urged to register so that an accurate record may be kept of the attendance.)

Business Sessions, Clinical Center Council Meeting—9:00 A.M. to 9:30 A.M.—Board Room; House of Delegates Meeting—9:30 to 11:00 A.M.—Auditorium

Scientific Seminars—11:00 A.M. to 12:45 P.M., Clinical Center Building

(A) *National Heart Institute*

Recent Advances in the Study of Atherosclerosis.

A review of current research on the role of hyperlipemia in the genesis of human atherosclerosis, with a discussion of the "Gofman particles," low cholesterol diets, and the usefulness of cholesterol lowering drugs. EDWIN BOYLE, M.D.

The Role of Diuresis-Promoting Agents in the Management of Congestive Heart Failure.

A survey of the various diuresis-promoting agents such as mercurials, low-sodium diets, and cation exchange resins with a discussion of the mechanisms and importance of the various types of "low salt syndromes." LEROY DUNCAN, M.D.

*(B) National Institute of Arthritis and Metabolic Diseases**The Relative Merits of Gold Compounds, Cortisone and Butazolidin in the Treatment of Rheumatoid Arthritis.*

Discussion of the value of these various therapeutic agents, their indication for use and problems in management. Presentation of case. JOSEPH J. BUNIM, M.D.

Pitfalls in Insulin Therapy of Diabetes Mellitus.

Discussion of the difficulty in bringing patients into stable insulin control because of the phenomenon of paradoxical hyperglycemia, which occurs in greater frequency than is usually appreciated. Methods of recognizing the gradual onset of hypoglycemia, occurring with considerable frequency in the use of long acting insulins, will also be discussed. Presentation of case. GERALD T. PERKOFF, M.D.

(C) National Cancer Institute

Endocrine Aspects of Cancer Therapy. ROY HERTZ, M.D.

Medical Management of Neoplastic Diseases. LEONARD D. FENNINGER, M.D.

*(D) National Microbiological Institute**Brucellosis.*

A discussion of the clinical and laboratory criteria for the diagnosis of brucellosis and an evaluation of current methods of therapy. NORMAN B. MCCULLOUGH, M.D.

Amebiasis.

A discussion of the criteria for diagnosis of amebiasis and for follow-up evaluation of the treated case. CLARENCE IMBODEN, M.D.

*(E) National Institute of Neurological Diseases and Blindness**Analysis of a Case of Temporal Lobe Seizures.*

This patient has suffered from focal cerebral seizures arising within the temporal lobe. His case is analyzed with regard to neurological examination, historical data, radiographic findings and electrographic studies. The radical treatment and the pertinent findings from stimulation and electrocorticography are discussed. The psychological, neurochemical and neuropathological aspects of the patient and his lesion will be outlined by representative personnel and the immediate results summarized. STAFF.

Analysis of a Case of Neuromuscular Disease.

This case is analyzed with regard to the neurological examination, the genetic background, the historical data, and the electromyographic studies. The methods of investigation are briefly outlined in reference to muscle protein studies, radioactive ionic exchange studies, and pathological conformation of disease. The methods by which changes in muscle proteins, dynamics, and ionic exchange may be brought about by ionic resins, steroids, etc., will be briefly discussed. STAFF.

*(F) National Institute of Mental Health**Experimental Psychoses Produced by Lysergic Acid.*

Lysergic diethyl amide [LSD-25] given orally in single doses as low as 10 micrograms produces depersonalization, hallucinations, and schizophrenia-like symptoms in "normal" individuals. Much larger doses are required to produce effects on mental patients. Lysergic acid affords insights into the genesis of mental symptoms. CHARLES SAVAGE, M.D.

Research Needed in Residential Treatment of Children.

With the increased awareness of the need for residential treatment, especially for aggressive and destructive children and youth, the psychiatric implications of the ward setting of children's activities and of the handling of aggressive behavior pose new problems. This discussion will describe and evaluate some of the research implications which have come to our attention. FRITZ REDL, Ph.D.

Luncheon—12:45 P.M. to 1:45 P.M. Cafeteria "Get what you want and pay for it!"

General Meeting—2:00 P.M., Auditorium, Clinical Center

1. Address of Welcome. WILLIAM S. MURPHY, M.D., *President*, Montgomery County Medical Society.
2. Response. MAURICE C. PINCOFFS, M.D., *President*, Medical and Chirurgical Faculty of the State of Maryland.
3. Presentation Honoring Montgomery County Medical Society. MAURICE C. PINCOFFS, M.D.
4. Historical Address. JACOB W. BIRD, M.D.

Scientific Session

5. Medical Research, the Physician, and Public Health. (I. Ridgeway Trimble Fund Lectureship.) LEONARD A. SCHEELE, M.D., *Surgeon General*, Public Health Service, U. S. Department of Health, Education, and Welfare, Washington, D. C.

Tours—3:30 P.M. to 5:00 P.M., Meet in Lobby, Clinical Center

National Institutes of Health, Bethesda.

OR

Homes: (*Hostesses will direct this tour.*)

The Alexander Casanges Home. Brick house of late Federal architecture is superimposed on an earlier one of "Flounder house" type. The oldest part of the house, consisting of four rooms, was built prior to 1790. The old hewn timbers are still doing service as beams in this part of the house. The house was built by Richard Thomas and Deborah Brooke Thomas on land inherited from Roger Brooke. Richard Thomas was one of the men who laid out and platted the village of Brookeville in 1798. The house passed into the hands of the Robertson-Howard family about 1815 and was owned and lived in by them until its sale to the present owners in 1949. The present owners, Mr. and Mrs. Alexander Casanges and Miss Anna P. Holdridge, restored and renovated it for present-day living. Several members of the Howard family were doctors, and others were connected with the Medical Profession. Brookeville's first Dr. Henry Howard was born in Howard County, Maryland, in 1791, and came to Brookeville to practice medicine about 1815. He was Professor of Pathology and Materia Medica at the University of Maryland, Baltimore. He rode horseback over a dirt road, three times a week to Baltimore to lecture. In 1830 he was called to the same chair at the University of Virginia, in which he served until 1837. It was the residence and office of Dr. Flodoardo Howard from 1854-1869. During his time the house reached its final shape.

Ziegler's Choice. Original land grant from Lord Baltimore patented in 1725 by Thomas Bordley, known as Bordley's Choice. Sold in 1751 for the sum of £200 sterling to John Riggs, then sold to the Brookeville Academy. Additions were added 1850 to 1865. It is of solid stone with walls 24 to 36 inches thick. Original mantel hand cut in dining room. Old fan light over drawing room door. In 1941 the property was purchased by Dr. and Mrs. Mark V. Ziegler and the house completely restored preserving and reproducing all the old wood trim, mantels, floors, etc. Mrs. Ziegler has linen and woolen coverlet woven from flax and wool raised on the Ziegler Homestead about 1830; also Kentucky firearms.

Little Olney. An interesting and well restored old house, owned by the Farquhar family for many generations. Fine antiques and boxwood. Owned and restored by Mrs. Clara May Downey.

Pleasant Valley. Home of the overseer of Greenwood. Part of the original Davis Plantation. The fireplace dates back to 1740. After the Civil War it was the home of a local resident, Lafayette Dwyer. In 1945 the place was bought and restored by Mr. and Mrs. Ralph Heckman. It shows what can be done with an old nondescript place.

Golf—Green Fee \$1.00

1. Glenbrook Golf Course, 8600 Wisconsin Avenue, Bethesda, immediately adjacent to the grounds of the National Institutes of Health on the south with entrance marked on west side of Route 240.
2. White Flint Golf Course, Rockville Pike, about 2½ miles north of National Institutes of Health on Route 240, with entrance marked on east side of road.

Woman's Auxiliary to the Medical and Chirurgical Faculty

9:30 A.M. to 12 Noon

Administration Building

A cordial invitation is extended to all the ladies to attend this meeting.

Committees of the Montgomery County Medical Society

Arrangements Committee: DR. CHARLES H. LIGON, *Chairman*; DR. WILLIAM W. EASTMAN; DR. GEORGE A. GRAY, JR.

Entertainment Committee: (Composed of members of the Woman's Auxiliary to the Montgomery County Medical Society.)
MRS. E. G. BAUERSFELD, *Chairman*; MRS. WILLIAM D. AUD; MRS. J. MARION BANKHEAD; MRS. G. V. HARTLEY; MRS. MARK V. ZIEGLER.

ONE HUNDRED FIFTY-SIXTH ANNUAL MEETING

Medical and Chirurgical Faculty of the State of Maryland

1211 Cathedral Street, Baltimore 1, Maryland

ANNUAL MEETING PROGRAM

Monday, April 26, 1954—9:00 P.M. to 1:00 A.M.

MEDICAL AND CHIRURGICAL FACULTY BALL

THE ALCAZAR, Cathedral and Madison Streets

All the members, their wives, and guests are urged to attend THE BALL (dress optional), which is under the sponsorship of the Woman's Auxiliary to the Baltimore City Medical Society. Tickets \$3.00 per person and checks may be sent to Mrs. Robert W. Garis, Ambassador Apartments, Baltimore 18. Tickets may also be purchased at the door. The entertainment, "Medicana," will begin at 10:00 p.m. There will be the Coronation of Baltimore's "Outstanding Student Nurse." Raffle of mink stole!

SCIENTIFIC MEETINGS

Tuesday, April 27, 1954, Morning Session, Osler Hall (Entrance and Exit—Maryland Avenue)

BENDER B. KNEISLEY, M.D., *President*, Presiding

9:00 a.m. Motion Pictures.

1. Experimental Congenital Orthopedic Defects. Discussed by J. T. H. JOHNSON, M.D.

Produced at the Children's Hospital School by P. K. DURAISWAMI, M.D.

2. Treatment of Long Standing Cervical Disc Protrusions with Section of Dentate Ligaments. Discussed by JAMES G. ARNOLD, JR., M.D.

Produced at Mercy Hospital by AUGUST KIEL, JR., M.D.

10:00 a.m. Psychiatric Panel.

Moderator: HARRY M. MURDOCK, M.D., Medical Director, Sheppard and Enoch Pratt Hospital, Towson, Maryland.

Participants: Progress in Electro-Convulsive Therapy. FRANK J. AYD, M.D.

Brief Medical Psychotherapy and the Question of the Psychiatric Referral. KLAUS W. BERBLINGER, M.D., Assistant Professor of Psychiatry, University of Maryland School of Medicine. (By invitation.)

What Might the Private Practitioner Expect of the Public Psychiatric Hospital? CLIFTON T. PERKINS, M.D., Commissioner of Mental Hygiene, State of Maryland.

12 Noon. ELECTION OF THE BOARD OF MEDICAL EXAMINERS. (OSLER HALL)

12:15 p.m. Adjournment.

Tuesday, April 27, 1954, Afternoon Session, Osler Hall (Entrance and Exit—Maryland Avenue)

RALPH G. HILLS, M.D., *Vice-President*, Presiding

- 2:00 p.m. Clinical Pathological Conference by The Staff of The Johns Hopkins University School of Medicine. (Illustrated.) STANTON L. EVERSOLE, M.D., *Assistant Professor of Pathology*, The Johns Hopkins University School of Medicine. (By invitation.)

CHARLES W. WAINWRIGHT, M.D., *Associate Professor of Medicine*, The Johns Hopkins University School of Medicine.

- 3:00 p.m. Chemotherapy Panel. (Illustrated.)

Moderator: JOHN C. KRANTZ, JR., PH.D., *Professor of Pharmacology*, University of Maryland School of Medicine.

Participants: The Current Approach to the Chemotherapy of Tuberculosis. GLADYS L. HOBBY, PH.D., Biochemical Research Division, Charles Pfizer and Company, Inc., Brooklyn, New York.

Mechanism of Action of the Antibiotics. EDWARD STEERS, PH.D., *Associate Professor of Bacteriology*, University of Maryland School of Medicine. (By invitation.)

Broad Spectrum Antibiotics—Blood Dyscrasias and Chloramphenicol. HENRY WELCH, PH.D., *Director*, Division of Antibiotics, Food and Drug Administration, Department of Health, Education and Welfare, and Editor-in-chief, Antibiotics and Chemotherapy, Washington, D. C.

5:00 p.m. Adjournment.

Tuesday, April 27, 1954, Evening Meeting, Osler Hall (Use Cathedral Street Entrance), 8:00 p.m.

BENDER B. KNEISLEY, M.D., *President*, Presiding

1. Presidential Address.

Our Relations with the Public. BENDER B. KNEISLEY, M.D.

2. John M. T. Finney Fund Lecture.

Clues in Cardiovascular Diagnosis and Treatment. PAUL DUDLEY WHITE, M.D., Clinical Professor of Medicine, Harvard Medical School; Executive Director, National Advisory Heart Council and Consultant, Massachusetts General Hospital, Boston, Massachusetts.

3. Presentation of Portrait of Dr. John Ruhräh. FRED B. SMITH, M.D.

4. Necrology. A. S. CHALFANT, M.D., Chairman, Memoir Committee. (See page 454.)

(The members are requested to remain standing during the reading of the report.)

Wednesday, April 28, 1954, Morning Session, Osler Hall (Entrance and Exit—Maryland Avenue)

ERNEST I. CORNBROOKS, JR., M.D., *Vice-President*, Presiding

9:00 a.m. Motion Picture.

Intracardiac Surgery. Discussed by R ADAMS COWLEY, M.D., and LEONARD SCHERLIS, M.D.

Produced at the University of Maryland School of Medicine.

10:00 a.m. Cancer Panel. (Illustrated.)

Moderator: JOHN R. HELLER, JR., M.D., Director of the National Cancer Institute, Bethesda. (By invitation.)

Participants: Cancer Control in the United States. RAYMOND F. KAISER, M.D., *Chief*, Field Investigations and Demonstrations Branch, National Cancer Institute, Bethesda. (By invitation.)

Recent Trends in Therapeutic Radiology. WALTER T. MURPHY, M.D., *Director Therapeutic Radiology*, Roswell Park Memorial Institute, Buffalo.

Certain Advances in Cancer Research. STANLEY P. REIMANN, M.D., *Director*, Lankenau Hospital Research Institute, and Scientific Director of the Institute of Cancer Research, Philadelphia.

12 noon. Adjournment.

Wednesday, April 28, 1954, Round Table Luncheon, 12:30 P.M.

The Ballroom, Sheraton Belvedere Hotel, Charles and Chase Streets

1. Chemotherapy and Antibiotics. WARDE B. ALLAN, M.D.
2. Civil Malpractice. ROBERT D. BARTLETT, ESQ.
3. Prevention of Fetal Deaths. . GEORGE W. ANDERSON, M.D.
4. Common Neurological Lesions. . JAMES G. ARNOLD, M.D.
5. Common Tuberculosis Problems
EDMUND G. BEACHAM, M.D.
6. Removal of Acne Scars (Plastic Planing)
EUGENE S. BERESTON, M.D., R. C. V. ROBINSON, M.D.
7. Nose and Throat. JOHN E. BORDLEY, M.D.
8. Psychoneuroses. GEORGE H. PRESTON, M.D.
9. Diabetes. T. NELSON CAREY, M.D.
10. Vascular Diseases of the Extremities
JOHN N. CLASSEN, M.D.
11. Modern Cardiac Investigation. . R ADAMS COWLEY, M.D.
12. Radiation Therapy. ROBERT J. DICKSON, M.D.
London, England
13. Office Gynecology. WILLIAM K. DIEHL, M.D.
14. Proctology. MONTE EDWARDS, M.D.
15. Urology. ALBERT E. GOLDSTEIN, M.D.
16. Industrial Medicine. THURSTON R. ADAMS, M.D.
17. Endocrinology. JOHN EAGER HOWARD, M.D.
18. Urinary Tract Cancer. HUGH J. JEWETT, M.D.
19. Gynecological Cancer. HOWARD W. JONES, M.D.
20. Breech Presentation. D. FRANK KALTREIDER, M.D.
21. Hernia. AMOS R. KOONTZ, M.D.
22. Medical Ethics. LOUIS KRAUSE, M.D.
23. Pediatric Orthopedics. RAYMOND E. LENHARD, M.D.
24. Gall Bladder Disease. SAMUEL McLANAHAN, M.D.
25. Chest Problems. ROSS L. McLEAN, M.D.
26. Common Eye Problems. JOHN C. OZAZEWSKI, M.D.
27. Gastro-Intestinal Hemorrhage
MAURICE C. PINCOFFS, M.D.
28. Pathology. DEXTER L. REIMANN, M.D.
29. Common Skin Diseases. . HARRY M. ROBINSON, JR., M.D.
30. Usual Laboratory Procedures in Clinical Diagnosis
MILTON S. SACKS, M.D.
31. Poliomyelitis. ALEXANDER J. SCHAEFFER, M.D.
32. General Surgery. RICHARD T. SHACKELFORD, M.D.
33. Pediatric Acute Surgical Abdomen
DOUGLAS H. STONE, M.D.
34. Hypertension. CAROLINE BEDELL THOMAS, M.D.
35. Public Health. HUNTINGTON WILLIAMS, M.D.
36. Arthritis. CHARLES W. WAINWRIGHT, M.D.
37. Head and Neck Cancer. GRANT E. WARD, M.D.
38. Pediatric Endocrinology. LAWSON WILKINS, M.D.
39. Allergies. WALTER L. WINKENWERDER, M.D.

Wednesday, April 28, 1954, Afternoon Session, Osler Hall (Entrance and Exit—Maryland Avenue)

E. PAUL KNOTTS, M.D., *Vice-President*, Presiding

2:00 p.m. Clinical Pathological Conference by The Staff of the University of Maryland School of Medicine. (Illustrated.)

JOHN A. WAGNER, M.D., *Associate Professor of Pathology*, University of Maryland School of Medicine.

THEODORE E. WOODWARD, M.D., *Associate Professor of Medicine*, University of Maryland School of Medicine.

3:00 p.m. Diabetes Panel. (Illustrated.)

Moderator: J. SHELDON EASTLAND, M.D., *Associate Professor of Medicine*, University of Maryland School of Medicine.

Participants: Diabetic Acidosis. JOSEPH T. BEARDWOOD, JR., M.D., *Professor of Metabolic Diseases*, Graduate School of Medicine of the University of Pennsylvania, Philadelphia; Director of Medical Services, Abington Memorial Hospital, Abington, Pennsylvania.

Insulin Therapy for Diabetes. GARFIELD G. DUNCAN, M.D., *Clinical Professor of Medicine*, Jefferson Medical College, Philadelphia.

Question and Answer Period.

5:00 p.m. Adjournment.

Wednesday, April 28, 1954, Buffet Supper, 6:30 P.M. to 7:30 P.M., Osler Hall, 1211 Cathedral Street Entrance

The members are urged to bring their wives and guests to the Buffet Supper. A cordial invitation is extended to EVERYONE to attend the evening meeting.

Cover charge, \$5.00 per person. Reservations, accompanied by check, must be made prior to Thursday, April 22, 1954.

Evening Meeting, Osler Hall, 8:00 P.M. (Use Cathedral Street Entrance)

BENDER B. KNEISLEY, M.D., *President*, Presiding

1. Introduction of MRS. JOHN G. BALL, President, Woman's Auxiliary to the Medical and Chirurgical Faculty.

2. I. Ridgeway Trimble Fund Lecture.

Our Growing Responsibilities to the Aged in our Midst. RICHARD A. KERN, M.D., *Professor of Medicine*, Temple University School of Medicine, Philadelphia, Pennsylvania.

3. Drawing by the President of the Faculty for Prize of two one hundred dollar U. S. Savings Bonds—Series E. If winners are not present, drawing will continue.

4. "The Girl with the Lamp." Nurse Recruitment Film. *Produced by the Woman's Auxiliary to the Baltimore City Medical Society in cooperation with the Maryland Society for Medical Research and the teaching hospitals of Maryland.*

Exhibits will be open from 9:00 a.m. to 5:00 p.m.

EXHIBITORS

Prominent firms, dealing in books and supplies required by physicians, as listed below, will exhibit during the Annual Meeting of the Medical and Chirurgical Faculty.

Our thanks are extended to Hynson, Westcott & Dunning, Inc., who have kindly contributed to our Annual Meeting, although it was not convenient for them to exhibit.

We wish to express our appreciation to the Coca-Cola Bottling Company of Baltimore and the Seven-Up Bottling Company of Baltimore for the serving of free Coca-Cola and Seven-Up to those attending the Meeting.

1. A. S. Aloe Company
2. Ayerst, McKenna & Harrison Limited
3. The Baker Laboratories, Inc.
4. Beech-Nut Packing Company
5. A. J. Buck & Son
6. Coca-Cola Bottling Company of Baltimore
7. Herbert Cox—Correct Shoes
8. Desitin Chemical Company
9. Doho Chemical Corporation
10. The Drug Products Company, Inc.
11. Duke Laboratories, Inc.
12. E. Fougera & Company, Inc.
13. Graymar Company
14. Caroline deFord Hinrichs
15. Kloman Instrument Company, Inc.
16. The Liebel-Flarsheim Company
17. Eli Lilly and Company
18. Massachusetts Indemnity Insurance Company
19. Mead Johnson & Company
20. Murray-Baumgartner Surgical Instrument Company, Inc.
21. Nepera Chemical Company, Inc.
22. Ortho Pharmaceutical Corporation
23. Parke, Davis & Company
24. Pfizer Laboratories
25. William P. Poythress & Company, Inc.
26. A. H. Robins Company, Inc.
27. J. B. Roerig and Company
28. W. B. Saunders Company
29. G. D. Searle & Company
30. Seven-Up Bottling Company of Baltimore
31. Similac Division, M & R Laboratories
32. Raymond K. Tongue Company, Inc.
33. The Upjohn Company
34. U. S. Vitamin Corporation
35. Walker Laboratories, Inc.
36. The Williams & Wilkins Company

SUBCOMMITTEE ON EXHIBITS

EDWIN H. STEWART, JR., M.D., *Chairman*, Baltimore

MICHAEL I. O'CONNOR, Baltimore

JOHN A. STREVIG, PHAR.D., Baltimore

* * * * *

Representative of Railway Express Agency, Mr. E. R. Redding, will be available for information during the meeting.

COMMITTEE TO COOPERATE WITH AMERICAN MEDICAL EDUCATION FOUNDATION

Mr. President and Members of the House of Delegates:

It will probably come as a surprise to Maryland physicians, many of whom are graduates of either the University of Maryland or Hopkins, that their schools received from the American Medical Education Foundation over and above any connected with the recognized alumnae fund approximately \$25,000 each in the year 1953. This grant of \$50,000 to the medical schools of the state of Maryland was made in full recognition of the fact that the practicing physicians in Maryland and teaching staffs combined made a total contribution to the fund of less than one-eighth the total amount of that grant, that is \$6,452. In addition, that amount of \$6,452 was raised from 3.23% of the doctors in active membership of the Medical and Chirurgical Faculty of Maryland.

Of our more than 3,900 doctors in Maryland 127 physicians felt the desire to respond to this method of maintaining the high standards in our medical schools that it was their privilege to enjoy. The Chairman of the A.M.E.F. State Committee is grateful to all who cooperated in this total contribution and many good ideas are being considered to make it not only possible but more attractive for physicians to give to the foundation in the coming year.

This includes the Audio-Digest-Lecture-Service about which you will hear more. Profits of their project will go to the American Medical Education Foundation.

States such as Illinois with a membership of 13,000 through assessment gave over \$190,000 to the A.M.E.F. and Iowa also through assessment with a membership less by 1,000 than that of Maryland gave over \$9,000. It is hoped that these figures will stimulate those who have not been contributing into thinking in terms of positive action to be taken in the year 1954 in support of the American Medical Education Foundation.

Respectfully submitted,

NEWLAND E. DAY, M.D., *Chairman*

THURSTON R. ADAMS, M.D.

WALTER A. BAETJER, M.D.

JOHN G. BALL, M.D.
 J. H. BATES, M.D.
 KATHERINE A. CHAPMAN, M.D.
 STUART CHRISTHILF, JR., M.D.
 H. V. DAVIS, M.D.
 WILFRED W. EASTMAN, M.D.
 CHARLES R. FOUTZ, M.D.
 J. STANLEY GRABILL, M.D.
 DONALD B. GROVE, M.D.
 WILLIAM B. HAGAN, M.D.
 L. A. HOFFMAN, M.D.
 PHILIP A. INSLEY, M.D.
 W. O. McLANE, JR., M.D.
 ERNEST F. POOLE, M.D.
 PAUL H. ROYSE, M.D.
 THEODORE R. SHROP, M.D.
 M. H. SPRECHER, M.D.

BLOOD BANK ADVISORY COMMITTEE

Mr. President and Members of the House of Delegates:

The Blood Bank Advisory Committee of the Medical and Chirurgical Faculty has had no requests for information or action since its report of March 1953.

Respectfully submitted,
 MERRELL L. STOUT, M.D., *Chairman*
 C. LOCKARD CONLEY, M.D.
 KENDRICK McCULLOUGH, M.D.
 WALTER C. MERKEL, M.D.
 H. RAYMOND PETERS, M.D.
 MILTON S. SACKS, M.D.
 BENEDICT SKITARELIC, M.D.
 JOHN WHITRIDGE, JR., M.D.

ARMY MEDICAL LIBRARY COMMITTEE

Mr. President and Members of the House of Delegates:

No meeting has been held during the year because nothing further has been done in Washington, so far as we can learn, in regard to a new Army Medical Library.

Respectfully submitted,
 ANDREW C. GILLIS, M.D., *Chairman*
 JOHN T. KING, M.D.
 JOHN E. SAVAGE, M.D.
 LAWRENCE R. WHARTON, M.D.
 WALTER D. WISE, M.D.
 SAMUEL WOLMAN, M.D.

BUDGET COMMITTEE

Mr. President and Members of the House of Delegates:

The Budget Committee, as appointed in the fall of 1953, by the Chairman of the Council, Dr. C. R. Edwards, met with the Finance Committee on Wednesday, January 20, 1954, for the consideration of the current expenses of the Medical and Chirurgical Faculty and the budget as outlined for 1954.

After considerable discussion, which was mostly in the form of explanations on the current expenses by Mr. Kirkman, it was the unanimous opinion that the current expenses as outlined were justified and the budget for 1954 was acceptable.

A copy of the budget is as follows:

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

1954 BUDGET

ESTIMATED INCOME

<i>From Dues</i>			
Baltimore City members (1334).....	\$57,900.00		
County members (924).....	26,980.00	\$84,880.00	
Baltimore City Medical Society			
For use of facilities.....	400.00		
For secretarial services.....	3,100.00	3,500.00	
Baltimore City Dental Society			
469 members at \$3.00.....		1,407.00	
State Board of Medical Examiners			
Rental for 1215 Cathedral Street.....	1,680.00		
Rental for Osler Hall.....	480.00	2,160.00	
State Board of Nurses Examiners			
Rental for Osler Hall.....		240.00	
State Nurses Association			
Rental for 1217 Cathedral Street.....		2,000.00	
Forward.....		\$94,187.00	

Maryland League for Nursing			
Rental for 3rd floor, 1215 Cathedral Street			360.00
State Veterinarian Board			25.00
<i>Income from Invested Funds</i>			
<i>For General Purposes</i>			
Bowen Fund	\$668.00		
Bressler Fund	140.00		
Contingent Fund	356.00		
Ellis Fund	1,072.00		
Osler Endowment Fund	108.00		
Osler Testimonial Fund (½)	331.00		
Ruhräh Fund (½)	2,016.00		
Hiram Woods Fund	171.00	4,862.00	
<hr/>			
<i>For Special Purposes</i>			
Cordell Fund	295.00		
Friedenwald Fund	57.00		
Trimble Fund	205.00	557.00	
<hr/>			
Forward		\$5,419.00	\$94,572.00
<hr/>			
<i>For Library Purposes and Lectures</i>			
Baker Fund	\$45.00		
Barker Fund	30.00		
Cowles Fund	25.00		
Finney Fund	663.00		
Frick Fund	1,146.00		
Harlan Fund	64.00		
McCleary Fund	60.00		
Osler Testimonial Fund (½)	331.00		
Stokes Fund	337.00		
Ruhräh Fund (½)	2,016.00	4,717.00	10,136.00
<hr/>			
Income from Annual and Semiannual Meetings (see contra)			5,401.00
Income from Journal Advertising and Subscriptions (see contra)			17,358.00
<hr/>			
Total			127,467.00
Less uncollectible dues and possible lower return on investments			2,467.00
<hr/>			
			\$125,000.00

ESTIMATED DISBURSEMENTS

	1953 Expenditures	1954 Estimated	1954 + \ Compared - / With 1953
1. Auditor	\$405.00	405.00	—
2. Communications	3,172.00	3,200.00	—28.00
3. Contributions	120.00	120.00	—
4. Fuel	2,582.00	2,600.00	+18.00
5. Gas, Electricity and Water	2,209.00	2,300.00	+91.00
6. Household and janitorial supplies and expense	515.00	600.00	+85.00
7. Insurance	1,272.00	1,300.00	+28.00
8. Interest	212.00	—	—212.00
8a. Journal expense	20,944.00	20,944.00	—
9. Legal fees	751.00	851.00	+100.00
10. Library expense, i.e. books, journals, supplies, etc.	4,399.00	4,399.00	—
11. Maintenance of property	1,459.00	1,459.00	—

	1953 Expenditures	1954 Estimated	1954 + \ Compared - / With 1953
12. Meetings—Annual and Semiannual	\$6,645.00	7,500.00	+855.00
13. Miscellaneous	3,525.00	3,525.00	—
14. Office Equipment	657.00	750.00	+93.00
15. Office Supplies	891.00	900.00	+9.00
16. Printing	1,733.00	1,800.00	+67.00 *
17. Salaries and wages	48,156.00	48,310.00	+154.00
18. Taxes	1,568.00	2,020.00	+452.00
19. Travel	791.00	1,400.00	+609.00
20. Legislative expense	51.00	100.00	+49.00
21. New equipment	77.00	1,888.00	+1,811.00
22. Reserve for extraordinary repairs and improvements	1,398.00	3,500.00	+2,102.00
23. Transactions	854.00	850.00	—4.00
	<hr/> \$104,386.00	<hr/> 110,721.00	<hr/> +6,335.00

ADDITIONAL ITEMS REQUESTED

3 Stenographers at	\$2,600.00	7,800.00	7,800.00
1 Janitor		1,900.00	1,900.00
1 Typist for Library		2,080.00	2,080.00
Library expense	4,399.00		
	<hr/> 760.00		
	5,159.00		
	<hr/> —4,717.00	442.00	442.00
		<hr/>	
Service to Committees		1,500.00	1,500.00
Special Accounts (per contra)		557.00	557.00
		<hr/>	
Total	\$104,386.00	125,000.00	20,614.00

Respectfully submitted,
WETHERBEE FORT, M.D., *Chairman*
ROBERT V. CAMPBELL, M.D.
RICHARD C. DODSON, M.D.
ROBERT C. KIMBERLY, M.D.
NORMAN E. SARTORIUS, JR., M.D.

CANCER COMMITTEE

Mr. Chairman and Members of the House of Delegates:

As you may note the personnel of the Cancer Committee for the past year has been greatly reduced in number for there seemed no great necessity for other than a skeletal organization which can be augmented when the necessity arises.

The vast majority of the work in the State has been conducted by the very efficient Maryland Division of the American Cancer Society. Their work has been outstanding and every year increases in scope. At present the campaign is beginning for the annual fund, which is \$316,000, and judging from past experience I am sure this will be collected. Their many activities include Detection Centers, talks before medical and lay societies, pathological service, supplying of drugs and dressings, financial assistance to the medically indigent, grants-in-aid for cancer research, etc. Several motion pictures on the subject of malignancy have been purchased and are available to the various societies. We, here in Baltimore, have been active in giving television presentations of the treatment of malignant diseases and this has been of great value as

proven by requests for their repetition. I am glad to say that as each year transpires the message of cancer control reaches more people and we are seeing fewer patients with marked evidence of cancer phobia.

We feel that the education of the people has made great strides and the individual is ever alert as to the possibility of its development. In re new methods of radiation therapy, several procedures have been developed which we believe will be very fruitful and tend to augur a greater percentage of cures.

Mrs. Thomas Cullen has given her residence on Eager Street as a permanent home for the Maryland Division of the American Cancer Society; however, this is being rehabilitated so that the office is still maintained at their present location, 1900 St. Paul Street. Anyone wishing more detailed information as to the Cancer Program in Maryland may contact this office at the above address.

Respectfully submitted,
J. MASON HUNDLEY, JR., M.D., *Chairman*
C. BERNARD BRACK, M.D.
(See next page)

L. H. BRUMBACK, M.D.
 L. CLARENCE COHN, M.D.
 BEVERLEY C. COMPTON, M.D.
 WILLIAM K. DIEHL, M.D.
 WYLIE M. FAW, JR., M.D.
 GERALD A. GALVIN, M.D.
 HOWARD W. JONES, JR., M.D.
 JAMES T. MARSH, M.D.
 WILLIAM NEILL, JR., M.D.
 WILLIAM D. NOBLE, M.D.
 ARTHUR G. SIWINSKI, M.D.
 EDWIN H. STEWART, JR., M.D.
 RICHARD W. TELINDE, M.D.
 JAMES B. THOMAS, M.D.
 GRANT E. WARD, M.D.
 DALTON M. WELTY, M.D.

COMMITTEE ON CONSTITUTION AND BY-LAWS

Mr. President and Members of the House of Delegates:

Your Committee on Constitution and By-Laws offers the following amendments to the Constitution for final action by the House of Delegates at its meeting in April, 1954. (Amendments appear in capital letters.)

It will be recalled that these amendments were presented and approved, Tuesday, April 28, 1953.

ARTICLE V—House of Delegates Section 2.

The House of Delegates shall consist of (1) delegates elected by the component societies, each component society being entitled to elect one delegate for each 50 active members in good standing, or major fraction thereof; provided each component society shall be entitled to elect at least one delegate; (2) the membership of the Council; (3) ex-officio, the President, the incoming President, the immediate past President, the Chairman of the Library Committee, the delegates to the House of Delegates of the American Medical Association; and (4) one member elected by the State Board of Medical Examiners.

Amendment:

Delete: (3) EX-OFFICIO, THE PRESIDENT, THE INCOMING PRESIDENT, THE IMMEDIATE PAST PRESIDENT, THE CHAIRMAN OF THE LIBRARY COMMITTEE, THE DELEGATES TO THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION: AND (See page 413.)

Change: Number (4) to read (3) (See page 413.)

Explanation: This Section has been deleted on recommendation of the Council as ARTICLE VI, Section 2, contains this information. Take note, in this Section, that the following has not been amended: "one member elected by the State Board of Medical Examiners."

ARTICLE VI—Council Section 2.

The Council shall consist of (1) fifteen Councilors; and (2) the President, the immediate past President, the Presi-

dent-elect, the Secretary, the Treasurer, and the Chairman of the Library Committee, and Delegates to the American Medical Association House of Delegates, AND CHAIRMAN OF THE COMMITTEE ON CONSTITUTION AND BY-LAWS. (See page 413.)

Amendment:

Delete: AND (after Treasurer) (See page 413.)
 AND (after Committee)

ARTICLE VII—Officers Section 3.

All officers, except Councilors, shall serve a term of one (1) year. The term of the Councilors shall be for three (3) years from the date of their installation into office, PROVIDED HOWEVER THAT NO COUNCILOR MAY SERVE MORE THAN TWO (2) CONSECUTIVE ELECTED TERMS. (See page 414.)

Explanation: The Resolution presented and adopted by the House of Delegates September 1952, regarding terms of Councilors, will be recalled. "Be it Resolved that the Baltimore County Medical Association recommends that the elected members of the Council of the Medical and Chirurgical Faculty of the State of Maryland be limited to two (2) consecutive terms."

(Presented and approved, Wednesday, April 29, 1953.)

ARTICLE VIII—Sessions and Meetings Section 2.

Special meetings of either the Faculty or the House of Delegates may be called by the President or on petition of 10 delegates or 20 members respectively.

Amendment:

Change: Figure "20" to read: "50" (See page 414.)

Explanation: At present, the membership is approximately 2,451, and there are approximately 79 members of the House of Delegates. Our Committee called attention to ARTICLE VIII, Section 2, pertaining to Sessions and Meetings and questioned whether twenty (20) members is not too small a number to petition for special meetings of either the Faculty or the House of Delegates, in view of the growth of the Medical and Chirurgical Faculty, and recommended that the figure be changed to fifty (50).

For method of adoption the following is quoted from the Constitution Article XIV Amendments. The House of Delegates may amend any article of this Constitution by a two-thirds vote of the Delegates present at any Annual Session, provided that such amendment shall have been presented in open meeting at the previous annual, semiannual session or special session, and that it shall have been sent officially to each component society at least two months before the meeting at which final action is to be taken.

The above Amendments were sent officially to each Component Society February 25th, 1954. They are now presented for your final action.

The following Amendment to the By-Laws is proposed: CHAPTER II, Section I (d), under Dues and Assessments now reads:

"The dues of a licensed physician in Maryland who holds an academic position on a full time salary basis,

other than as a fellow or house officer, shall be \$15.00 per annum during the first five years of his academic position."

The Special Committee appointed by Dr. Pincoffs, President, November 3, 1953, to study the above section of the By-Laws dealing with the dues of licensed physicians holding academic positions recommends that this Section be amended to read as follows:

"THE DUES OF A LICENSED PHYSICIAN IN MARYLAND WHO HOLDS AN ACADEMIC POSITION ON A STRICT FULL TIME SALARY BASIS, OTHER THAN AS A FELLOW OR HOUSE OFFICER, SHALL BE \$10.00 PER ANNUM AS LONG AS HE HOLDS A RANK BELOW THAT OF AN ASSOCIATE PROFESSOR." (See page 414.) (See page 405 for action of House of Delegates and page 463 for Report of Special Committee in Regard to Dues of Academic Physicians.)

For method of adoption of By-Laws the following is quoted: CHAPTER XI Amendments. These By-Laws may be amended at any Annual Meeting of the House of Delegates by a majority vote of all the delegates present at that session, after the amendment has laid on the table for one day; or at any Semiannual Meeting by a majority vote of all the delegates present at that session, providing the amendment has been sent officially to all the delegates at least 30 days prior to the Semiannual Meeting.

This Amendment is now presented and if approved final action will be taken at the Wednesday morning, April 28, 1954, meeting. (See page 414.)

Respectfully submitted,

A. AUSTIN PEARRE, M.D., *Chairman*

E. COWLES ANDRUS, M.D.

DONALD HOOKER, M.D.

W. HOUSTON TOULSON, M.D.

EUGENE FAUNTLEROY CORDELL FUND COMMITTEE

Mr. President and Members of the House of Delegates:

There were no beneficiaries during 1953 from this Fund. The original amount of the Cordell Fund was \$4847.97. During the years very little of the income has been used, since the requests for assistance have been few. As a result, the income has accumulated until now it exceeds the principal, the total amount being \$5197.19. In December of 1953 the Finance Committee authorized that some of this accumulated income be invested and 27 shares of Eastman Kodak Company common stock and 100 shares of the Maryland Casualty Company common stock were purchased, amounting to \$4127.07. This leaves a cash balance in the Fund of \$1070.12. Should the need ever arise these investments can be sold and the money used the same as previously.

Respectfully submitted,

T. NELSON CAREY, M.D., *Chairman*

JAMES K. GRAY, M.D.

WILLIAM L. HOWARD, M.D.

FRANK F. LUSBY, M.D.

GEORGE ALLEN MOULTON, JR., M.D.

CURATOR

Mr. President and Members of the House of Delegates:

Last year (1953), I made the first formal report on our valuable collections of books, portraits and many other museum pieces inherited from the past. I can only add a few words to my report of last year; the same things are there and have been for years, and each year, as this year, more are added. Our most important acquisition is the portrait of Dr. John Ruhrah, which is to be presented to the Faculty during this Annual Meeting by Dr. Fred B. Smith. (See page 402.)

Who knows about or sees these things? Who knows about the Washington Medical College? Who knows who founded it? What year (1827); where located? You can find all the *answers* to this and many other questions and at the same time enjoy our other valuable relics of the past; only if you come to *your* building and see *your* possessions, can you feel the *pleasure* that *only* is given to you through *your eyes*.

If you don't come, then the pleasure is lost. Do come, I am sure a few minutes of your time will be amply repaid.

Respectfully submitted,

J. ALBERT CHATARD, M.D.

DIABETES DETECTION COMMITTEE

Mr. President and Members of the House of Delegates:

The objective of this Committee is to find those individuals who have diabetes and are unaware of it and refer them to the physician of their choice for treatment.

During the week of November 15 through 21, 1953, a detection center was maintained at the 104th Medical Battalion Maryland National Guard Armory, Baltimore. The center was open to the public from noon to 9:00 p.m. In this way facilities were made available to large groups of employed as well as unemployed people. This Drive was unique in that it was not a fund raising campaign. Its conduction and success was entirely dependent on volunteer assistance. The Committee appreciates the untiring efforts of the following—Maryland Dietetic Association, Maryland Association of Hospital Auxiliaries, Maryland Pharmaceutical Association, Baltimore Retail Druggist Association, Baltimore City and Maryland State Departments of Health, Maryland Tuberculosis Association, the 104th Medical Battalion Maryland National Guard and the United States Public Health Service. Governor Theodore R. McKeldin proclaimed the week as Diabetes Week in the State of Maryland. Mayor Thomas D'Alesandro, Jr., not only proclaimed the week for the City of Baltimore, but was the first person to be screened at the center.

Each individual coming to the center had a specimen of urine, voided 1 to 2 hours after a meal, and a sample of blood tested for sugar. Blood sugar determinations were made by the Wilkerson-Heftmann Method utilizing the new Hewson Clinitron. An X-ray examination of the chest not primarily for diabetes but still most important, was carried out on those who so desired.

Exhibits on diabetes—diabetic diets, drugs and sundries used in the treatment of diabetes and educational displays were viewed and enjoyed by all.

A total of 3266 persons received blood and urine tests for

diabetes. Of these persons tested, 217 were positive, 96 of whom had no previous history of diabetes. Assistance was given to a local Industrial Clinic where 3104 additional individuals were screened.

Important objectives are accomplished by drives of this kind—a substantial number of unknown cases are found, many patients known to have diabetes but neglecting themselves are inspired to resume proper and adequate treatment, and the diabetic as well as the general public learns to understand diabetes better through the sound and authoritative information released at the center and through such public channels as radio, television and the press.

The activity and scope of this committee has grown year by year and it is now felt that more assistance from the Faculty in the way of clerical help and financial aid should be forth coming if it is desired that this work continue. (See page 411.)

Respectfully submitted

J. SHELDON EASTLAND, M.D., *Chairman*
E. IRVING BAUMGARTNER, M.D.
T. NELSON CAREY, M.D.
JAMES D. CARR, M.D.
J. WILFRID DAVIS, M.D.
PERRY FUTTERMAN, M.D.
FRANK J. GERAGHTY, M.D.
DAVID J. GILMORE, M.D.
LEWIS P. GUNDRY, M.D.
J. ROY GUYTHER, M.D.
JOHN H. HORNBAKER, M.D.
BENJAMIN F. JONES, M.D.
CHARLES F. O'DONNELL, M.D.
HAROLD PLUMMER, M.D.
J. EMMETT QUEEN, M.D.
GEORGE G. SCHLESINGER, M.D.
FRANK M. SHIPLEY, M.D.
A. A. SILVER, M.D.
BENEDICT SKITARELIC, M.D.
RALPH S. STAUFFER, M.D.
LESTER A. WALL, JR., M.D.

MARYLAND STATE MEDICAL JOURNAL, Editor

Mr. President and Members of the House of Delegates:

During the past year it has been possible to organize the editorial staff of the Maryland State Medical Journal on a much more satisfactory basis. Office space has been allotted and a secretary has been obtained. It is believed that this will eventually result in a much more superior type of Journal.

The Journal, generally speaking, seems to be popular with the majority of the membership. Advertising has been satisfactory, however, it would be of extreme help if more local advertising could be obtained. It is hoped that the Journal eventually can be placed on a basis where it becomes entirely self-supporting. At the present time it seems that continuation of the dollar and a half contribution from the membership dues of each member is requisite.

Respectfully submitted,

GEORGE H. YEAGER, M.D., *Editor*

GERIATRICS COMMITTEE

Mr. President and Members of the House of Delegates:

The activities of the Committee on Geriatrics of the Medical and Chirurgical Faculty of the State of Maryland during the past year have been carried out jointly with the Committee on Geriatrics of the Baltimore City Medical Society. During the year there were held three clinics on Geriatrics; at Levindale, City Hospitals, and the Baltimore Home for Incurables. There was also formed a small circulating library of books on Geriatrics which made the rounds through a number of hospitals in the city of Baltimore. The committee is contemplating to pass on the library to some of the hospitals in the counties.

Recently, the Committee on Geriatrics of the Baltimore City Medical Society has taken on a project in cooperation with the Baltimore Museum of Art. The State Committee is joining, in the carrying out of the activities connected with this project.

Briefly, the project consists of an exhibition of paintings depicting the processes and the effects of Aging on the human body including, the facial expressions, indicating the inner emotions, frustrations, disappointments as well as achievements of the aged person. The exhibition will also present works of art by the old masters as well as contrasts, of what the artist produces in his younger days and in his advanced years.

The exhibition will last from October 19th of this year to the end of November, a period of about six weeks.

During the period of the exhibition a number of activities will be arranged. These will consist of seminars, panels, conducted visits to the exhibition and a number of receptions to individuals or groups.

The present indications are that many segments of the community will participate in this project. It is hoped that the exhibition as a backdrop to the various programs, will add considerably to the public interest in the multiplicity of the problems of the Aging members of the community.

Respectfully submitted,

HERMAN SEIDEL, M.D., *Chairman*
WALTER A. ANDERSON, M.D.
THURSTON HARRISON, M.D.
LAURISTON L. KEOWN, M.D.
LOUIS KRAUSE, M.D.
NATHAN E. NEEDLE, M.D.
A. AUSTIN PEARRE, M.D.

COMMITTEE ON INDUSTRIAL HEALTH

Mr. President and Members of the House of Delegates:

The Committee on Industrial Health held several meetings in the course of the year. As compared with the work of similar committees in other states, we have not been able to enlist the cooperation or interest of industry, and this is to be regretted. However, we feel that we have functioned as a clearing house for information on matters of industrial health, and have been consulted by a number of physicians, several industrial nurses, and at least one business organization.

In addition, we have been able to give advice on the placement of physicians who are interested in obtaining work of this

sort. The dissemination of knowledge, particularly concerning occupation diseases amongst physicians, is important, and members of the Committee have carried out a number of speaking engagements on one phase or another of the diagnosis, prevention or treatment of such diseases.

Respectfully submitted,

NATHAN B. HERMAN, M.D., *Chairman*
 ROBERT VAN LIEU CAMPBELL, M.D.
 ROBERT F. CHENOWITH, M.D.
 WALTER E. FLEISCHER, M.D.
 WILLIAM L. GARLICK, M.D.
 HUGH C. GILL, M.D.
 W. R. HODGES, JR., M.D.
 JOHN V. HOPKINS, M.D.
 ROBERT H. RILEY, *ex officio*, M.D.
 BENJAMIN H. RUTLEDGE, M.D.
 LEROY W. SAUNDERS, M.D.
 W. KENNEDY WALLER, M.D.
 WILLIAM F. WILLIAMS, M.D.
 HUNTINGTON WILLIAMS, *ex officio*, M.D.

LEGISLATIVE COMMITTEE

Mr. President and Members of the House of Delegates:

Since the 1954 Session of the Maryland General Assembly was a "Short Session," little of medical interest was introduced and much of the material proposed was not acted on.

House Bill 27 concerning the definition of Chiropractic without any other provision was introduced and passed. Since this definition had been reviewed by the Council, we did not oppose this bill.

House Bill 147 provided for a change in the Advisory Board on Hospitalized licensing of the State Board of Health. After several conferences the bill was finally amended so as not to increase the number on the Board but to provide that one of the members nominated by the Hospital Association would be an owner or operator of a licensed nursing home. This was passed as amended.

Other bills relating to first, the Board of Homeopathic Physicians; second, House Bill 110 requiring a fee of \$1.00 from all patients treated at clinics conducted by the State Health Department; third, Senate Bill 58 concerning the Medical Board of the State Industrial Accident Commission; fourth, Senate Bill 106 concerning appeals from action of the Board of Medical Examiners in event of revocation of license of a practicing physician. These bills were considered but held in Committee without report either because of the fact that they were not emergency in nature or in the one case that the bill was improperly drawn.

The Legislative Committee desires to express its deep appreciation for the excellent work done by Mr. Walter Kirkman in this Session. He spent considerable time and effort in keeping track of the legislation and did a very effective job for the Society.

It is very evident that we must have a good legislative agent for the regular session coming up in 1955 and since we have been authorized to do so, your Committee, together with Mr. Kirkman, will see that the Society is well represented.

Respectfully submitted,

KARL F. MECH, M.D., *Chairman*
 FREDERIC V. BEITLER, M.D.
 THOMAS A. CHRISTENSEN, M.D.
 MELVIN B. DAVIS, M.D.
 GEORGE O. EATON, M.D.
 RAYMOND F. HELFRICH, M.D.
 WILLIAM T. LAYMAN, M.D.
 WILLARD S. PARSONS, M.D.
 DANIEL J. PESSAGNO, M.D.
 J. G. F. SMITH, M.D.
 JAMES E. STONER, JR., M.D.
 GEORGE E. URBAN, M.D.

MARYLAND MEDICAL SERVICE, INC.

Mr. President and Members of the House of Delegates:

This is the 4th annual meeting of Maryland Medical Service, and 1953 was its third full year of operation. It has been a year of steady and healthy growth, and our gains have been substantial. We as Trustees are now responsible for a very sizable operation, embracing over 220,000 persons in the community, with a growing annual income, approaching \$2,000,000 in 1953.

The year 1953 saw membership under our standard program increase by 33%, from 84,738 to 112,475 at the year end. Widening interest in the program is evidenced by the increasing number of groups enrolled—now a total of 2,985, or 565 more than were reported at the end of 1952. More and more groups with Blue Cross coverage are adding Blue Shield, and nearly all new groups sold are now taking both coverages. The outlook is encouraging.

Our income in 1953 was \$1,703,764, and out of this we paid 82.2% in benefits to subscribers. This percentage was slightly less than in the previous year, resulting in part from the adjustments in the fee schedule and subscription rates which were effected September 1, 1952. After all expenses, we were able to put 6.6% of income aside for reserves, somewhat more than in 1952. Funds available for reserves have not been wholly adequate in the three years of the Plan's operations, and the small additional amount available for reserves in 1953 was most welcome.

Benefits were paid in 1953 to some 22,913 subscribers, or about one out of every ten enrolled, as compared with 18,633 subscribers in 1952. Under the standard program only, 62% of the cases involved surgery, 26% were medical, and the remaining 12% obstetrical. The importance of in-hospital medical coverage, not available in many other Blue Shield Plans, is apparent from these figures.

The number of participating physicians also increased during the past year, to a new high of 1,736. This is concrete evidence of the increasing acceptance and support of the program by physicians throughout the State. And every doctor added to the list of participants increases the value of the Blue Shield program to the community.

Our biggest job ahead is a selling job. We are still a long way from our potential, having enrolled to date only 25% of the total Blue Cross subscribers. It is not an easy job, and is much more difficult than selling Blue Cross. Commercial competition

in the area of surgical and medical coverage is much keener than in the field of hospitalization, and our late start in Maryland means that in most large groups we are faced with replacing an existing surgical and/or medical insurance. Also, with the "service" feature limited to subscribers with incomes under \$4,000, this is simply not as powerful a selling factor as the service feature in Blue Cross. It applies to only about 50% of the subscribers, and for the remainder the program simply helps to pay the medical bills in exactly the same fashion as does commercial coverage.

Sooner or later a more realistic income provision must be established, and the fee schedule increased accordingly. Surgical care rendered in out-patient departments and in physicians' offices should be covered. But the Director believes, and I agree with him, that these and other improvements in the Plan should not be undertaken immediately but should await some further growth in membership. During our first three years of operation we have had to make several changes in fees and in rates; too frequent changes can be detrimental and lead to adverse reaction from both the public and the participating physicians. Also, we need a little more time to strengthen our finances and our reserve position.

The special surgical program for Bethlehem Steel, under which we had 109,000 persons enrolled at the year-end, will be re-negotiated in 1954, and I am informed that this program will be one of the first matters of business for the new Board of Trustees. The Director tells me that the changes proposed will be very extensive and that retention of this contract will present a major challenge to the Plan and to the medical profession this year. This has been an important piece of business for us locally, and it is a "prestige" account for Blue Shield nationally.

Dr. Henry F. Ullrich was elected President for 1954 of the Maryland Medical Service.

Respectfully submitted,
HUGH J. JEWETT, M.D., *President*
(See page 416.)

MATERNAL AND CHILD
WELFARE COMMITTEE

Mr. President and Members of the House of Delegates:

MATERNAL SECTION

During the year 1953 your Committee continued its activities with its principal interest the study of maternal deaths in the counties of Maryland. The Committee is happy to report a further reduction in maternal mortality and especially among the negro patients. Here for the first time, the rate is only one per thousand. Among white patients the rate is 0.5 and the combined is 0.6. The Committee feels that the cooperation of the Faculty in recommending more obstetrical beds for negro patients and the response of a number of the hospitals in the state to this request is responsible in a large measure for the reduction in mortality in this group.

During the year, 1953, there were 21 maternal deaths among the residents of the counties of Maryland. The causes of death are as follows:

Embolism (Amniotic Fluid 2).....	8
Toxemia.....	5
Hemorrhage.....	5
Infection.....	1
Anesthesia.....	1
Shock without hemorrhage.....	1

Of the hemorrhage deaths, 2 followed abortion, 2 followed term delivery and 1 was a case of placenta previa in which the patient received mis-matched blood. It may be that this death should not be assigned to hemorrhage.

Of these 21 deaths, autopsies were obtained in 8 or 38%. The Committee feels that this is a very pleasing percentage, but that it could and should be higher. All physicians are urged to do all in their power to raise this 38% of autopsies to as near 100% as possible.

Of the 21 deaths, the Committee reviewed 19, the remaining two being incomplete. Of these 19, it was felt that 9 or 47% should be judged preventable. This percentage of preventable deaths is the lowest we have ever had, the average of past years being around 65%. This speaks well for the care given obstetrical cases in our community. Among those for which the physician was held responsible, there were errors of commission and omission. These have been pointed out in individual letters to the attendants.

As in previous years the Committee was greatly impressed by the cooperation of the physicians in filling out the report forms and in presenting every possible bit of information about the deaths.

As for specific recommendation, the Committee requests that all hospitals in the state, either individually or in a group obtain a supply of "Fibrinogen" for use in those occasional cases of afibrinogenemia, more or less peculiar to pregnancy. This product can be life-saving if available and used properly. While moderately expensive, the cost is not prohibitive and the occasion for its use is rare. (See page 411.) At the same time that the procurement of this product is urged, the Committee feels that a word of caution is needed to the effect that it can easily be abused, and administered in non-indicated cases. A definite diagnosis of hypofibrinogenemia or afibrinogenemia should first be established.

PEDIATRIC SECTION

During 1953 the Pediatric Section continued to devote a large part of its time to the study of the causes of premature death in the counties of Maryland. Conditions associated with prematurity still account for the largest percentage of infant deaths in Maryland.

Preliminary figures for the State for 1953 show 1,673 infant deaths, with 739 deaths among premature infants, or approximately 44% of all infant deaths were associated with prematurity. There were 672 infant deaths with 281 premature deaths for Baltimore City among 22,632 live births, and 1,001 infant deaths with 458 premature deaths for the counties among 36,343 live births.

Final figures for Maryland for 1953 show that for the state as a whole 7.3% of the infants born weighed less than 5½

pounds (2500 grams) and were premature.* This small minority (7.3% of the births) were responsible for 44% of the deaths. It is evident that the problem of prematurity still constitutes by far the greatest problem in the further reduction of infant mortality. Continued effort should be made toward the prevention of prematurity by better maternity care as well as the improvement of hospital and home care of infants in the low weight groups.

Eighty-six survey forms were sent to physicians in the counties who reported deaths of prematurely born infants who survived 48 hours or more. 69 of these questionnaires were returned which shows excellent response from the physicians. These 69 deaths were reviewed by the Committee. The causes of death in order of their frequency were: immaturity, aspiration, infection, congenital anomalies, and intracranial hemorrhage. There were 29 autopsies performed among these 69 deaths. For the previous two years only, 14 autopsies a year have been reported. This shows a very commendable increase and adds considerably to the knowledge of the causes of premature deaths.

The general medical and nursing care given premature infants has steadily improved throughout the state during the past several years. The Pediatric Section continues to revise and keep up to date the brochure "Suggested Guide for the Care of Premature Infants" for the benefit of the physicians in the counties. Since the prolonged use of high oxygen concentration may be related to the development of retrolental fibroplasia, the section on the use of oxygen was revised in 1953.

The Pediatric Section investigated the possibility of reviewing all infant deaths. A small sampling was tried with questionnaires being sent out. The Committee felt from the information obtained on these questionnaires that there would be very little value derived from this undertaking and it was not pursued.

The Committee was quite concerned with the fact that despite a steady decline in the infant mortality rate the infant deaths in the first 48 hours of life have changed very little in the last 40 years. After analyzing the neonatal deaths for a period of about 6 months, it was found that many of the deaths within the first 48 hours were associated with obstetrical factors. The Pediatric Section referred this fact and the analysis of these deaths to the Maternal Section suggesting that the maternal committee undertake a survey of these deaths.

The Pediatric Section also requested that the Joint Committee urge that Blue Cross coverage be extended to include premature infants. The Pediatric Section has been advocating this for some time and now urged that both sections collaborate in again bringing this to the attention of the Blue Cross officials. (See page 411.)

Respectfully submitted,

LOUIS H. DOUGLASS, M.D., *Chairman*

J. EDMUND BRADLEY, M.D., *Vice-Chairman*

GEORGE W. ANDERSON, M.D.

ARTHUR BAPTISTI, JR., M.D.

JOHN MCF. BERGLAND, M.D.

* According to the definition used by the "Manual of International Statistical Classification of Diseases, Injuries, and Causes of Death 1948."

ANNIE M. BESTEBREURTJE, M.D.

HARRY D. BOWMAN, M.D.

THOMAS A. CHRISTENSEN, M.D.

STUART CHRISTHILF, JR., M.D.

GEORGE H. DAVIS, M.D.

DARIUS MCC. DIXON, M.D.

NICHOLSON J. EASTMAN, M.D.

H. W. ELIASON, M.D.

A. H. FINKELSTEIN, M.D.

S. BUTLER GRIMES, M.D.

WILSON GRUBB, M.D.

RUSSELL L. GUEST, M.D.

I. R. HANSON, M.D.

JANET B. HARDY, M.D.

PAUL HARPER, M.D.

JOHN S. HAUGHT, M.D.

W. ROYCE HODGES, JR., M.D.

WILLIAM K. MANSFIELD, M.D.

WILLIAM C. MORGAN, M.D.

J. MORRIS REESE, M.D.

JOHN E. SAVAGE, M.D.

ALEXANDER J. SCHAFER, M.D.

FRANCIS F. SCHWENTKER, M.D.

JEAN R. STIFLER, M.D.

WILLIAM C. STIFLER, JR., M.D.

BYRON D. WHITE, M.D.

JOHN WHITRIDGE, JR., M.D.

MEDICAL ADVISORY COMMITTEE TO SELECTIVE SERVICE

Mr. President and Members of the House of Delegates:

The Maryland Advisory Committee to Selective Service is still functioning, but due to the fact that no Priority III doctors are to be called into service before July 1, the number of doctors processed has dropped quite perceptibly. At the present time, only those doctors in Priority I and Priority II classifications who have Reserve Commissions are being called into the service.

I believe that after July 1, it will be necessary to call up some Priority III doctors born since August 30, 1922, for replacements for those doctors whose tour of duty has been completed. I see no evidence of the possibility of calling up doctors in Priority III over 32 years of age within the foreseeable future.

Respectfully submitted,

R. WALTER GRAHAM, JR., M.D., *Chairman*

COMMITTEE ON MEDICAL RESEARCH

Mr. President and Members of the House of Delegates:

I wish to submit a negative report for the Committee on Medical Research.

Respectfully submitted,

R. WALTER GRAHAM, JR., M.D.,
Chairman

ALFRED BLALOCK, M.D.

ALAN M. CHESNEY, M.D.

C. REID EDWARDS, M.D.

WARFIELD M. FIROR, M.D.
WETHERBEE FORT, M.D.
ALBERT E. GOLDSTEIN, M.D.
JOHN H. HORNBAKER, M.D.
DAVID I. MACHT, M.D.
STANLEY H. MACHT, M.D.
L. A. RADEMAKER, M.D.
W. ALFRED VAN ORMER, M.D.
THEODORE E. WOODWARD, M.D.
GEORGE H. YEAGER, M.D.
H. BOYD WYLIE, *ex officio*, M.D.

JOINT COMMITTEE WITH THE BAR
ASSOCIATIONS ON MEDICOLEGAL
PROBLEMS

Mr. President and Members of the House of Delegates:

This Committee is divided into the following: Symposium Management Subcommittee, Interprofessional Relations Subcommittee, and Court Procedure Subcommittee. These subcommittees have met during the past year.

However, the Symposium Management Subcommittee has met more frequently and arranged the meetings, which were held in Osler Hall, as indicated:

- 1. Use and Abuse of Drugs and Cosmetics, May 15, 1953. Participants: Mr. John S. Stanley, Dr. Kenneth C. Blanchard, Dr. Leslie N. Gay, Dr. Milton S. Sacks, Mr. Paul C. Wolman, Jr.
- 2. The Compulsory Use of Chemical Tests for Alcoholic Intoxication, October 23, 1953. Participants: Dr. Russell S. Fisher, Dr. John C. Krantz, Dr. Lewis P. Gundry, Mr. George D. Solter.
- 3. Symposium on the Medical and Legal Aspects of Malpractice, February 4, 1954. Participants: Mr. L. G. Sasscer, Dr. W. M. Firor, Dr. H. F. Ullrich, Mr. R. D. Bartlett, Mr. W. D. MacMillan.

These Meetings have been very well attended and interest has perhaps been greater for the legal profession than it is for the medical profession. This is easily understood because of the nature of the programs and of their respective interests. Certainly the enthusiasm of both groups has not diminished and it is anticipated that the symposia will continue and will certainly offer an opportunity for the legal and medical groups to better understand each other. The papers which are presented at these symposia are published in the Maryland State Medical Journal.

Respectfully submitted,
LOUIS KRAUSE, M.D., *Chairman*
CONRAD ACTON, M.D.
LEO BRADY, M.D.
RUSSELL S. FISHER, M.D.
MANFRED S. GUTTMACHER, M.D.
CHARLES A. REIFSCHNEIDER, M.D.
R. CARMICHAEL TILGHMAN, M.D.
I. RIDGEWAY TRIMBLE, M.D.
HENRY F. ULLRICH, M.D.
WALTER D. WISE, M.D.

MEMOIR COMMITTEE*

Mr. President and Members of the Medical and Chirurgical Faculty:

Each new year welcomes new faces into the membership of the Faculty at the same time that we must pause to mourn the loss of the old and familiar friends. The sense of continuing purpose in this fellowship of service has two uses. It tempers the youthful expectation of turning the world upside down for there are severe limitations on a mere man's strength and life span. At the same time it relieves the despondency of age, for there arise ever new energies to carry on the unfolding creation of a new and better world, when each life's end draws him back into the matrix of creative power, whose grace it is to accord each earnest soul an active participation in the expanding glory.

Our present scene has lost to the Cloud of Witnesses in the past year many names, whose memory spurs us on to stronger endeavour and a truer devotion to the ideals of service we have received and must pass on. Teachers, mentors, comrades, well-remembered figures in the Faculty, close friends in this full life, we hear their names with reverent affection.

Anne Arundel County

Willoughby, Maxwell Kemper.....November 29, 1953

Baltimore City

Bayer, Ira Eugene, Jr.....October 25, 1953
Baylor, John Ward.....November 25, 1953
Beissinger, Heinz Federick.....September 15, 1953
Branon, Alfred Brooks.....February 28, 1954
Cullison, Robert M.....November 4, 1953
Edlow, Ernest S.....April 25, 1953
Eisenberg, Albert.....April 24, 1953
Friedman, Paul N.....July 5, 1953
Galvin, Thomas K.....September 19, 1953
Hewitt, J. Frank.....November 13, 1953
Hutchins, Elliott Holdsworth.....August 24, 1953
Kelly, Bernard V.....April 14, 1953
Kieffer, Richard F.....April 1, 1953
Lillich, Bertram A.....August 15, 1953
Longcope, Warfield T.....April 25, 1953
Lubin, Paul.....December 23, 1953
Marvel, Norman Clyde.....February 2, 1954
Miller, Meyer.....January 11, 1954
Pound, John C., Sr.....November 27, 1953
Seliger, Robert Victor.....April 24, 1953
Sinskey, Henry L.....September 15, 1953
Skillman, Wilbur F.....November 6, 1953
Tenner, David.....May 30, 1953
Tonolla, E. Howard.....May 1, 1953
Wolf, Thomas Conrad.....August 25, 1953

* See Annual Meeting Program, Tuesday evening, April 27, 1954. (Page 442.)

Kent County

Dedman, James E. March 3, 1953
 Simpers, Henry G. September 9, 1953

Montgomery County

Bauersfeld, Emil G. December 13, 1953
 Gadol, William N. January 17, 1954

Prince George's County

Griffith, W. Allen. June 16, 1953

St. Mary's County

Camalier, F. A. November 8, 1953

Somerset County

Schwatka, C. Taylor. July 10, 1953

Talbot County

Stevens, A. Mc. C. January 31, 1954
 Willson, Spry Denny. April 8, 1953

Washington County

Norment, Robert Baxter. April 6, 1953

Wicomico County

Nock, Randolph M. December 15, 1953
 Williams, Jack K. July 27, 1953

Worcester County

Dickerson, John D. June 28, 1949

Respectfully submitted,
 A. S. CHALFANT, M.D., *Chairman*, Baltimore
 ARCHIE R. COHEN, M.D., Baltimore
 BENJAMIN KADER, M.D., Baltimore
 W. N. PALMER, M.D., Easton

MENTAL HYGIENE COMMITTEE**Mr. President and Members of the House of Delegates:**

At the request of the Secretary, this Committee considered a proposal of the American Medical Association Committee on Mental Health that a joint meeting be held of that Committee, the American Psychiatric Association, and the executives of the thirty or more organizations at a national level, active in the mental health field.

Your Committee recommended that the Medical and Chirurgical Faculty express its interest in and support of such a meeting.

Your Committee is conducting a panel discussion at the Annual Meeting on the morning of Tuesday, April 27, 1954. It is considering other activities, but is not yet ready to report upon them. It has no recommendations at this time.

Respectfully submitted,
 HARRY M. MURDOCK, M.D., *Chairman*
 DEXTER M. BULLARD, M.D.
 ROBERT E. GARDNER, M.D.

COMMITTEE ON NATIONAL EMERGENCY MEDICAL SERVICE***Mr. President and Members of the House of Delegates:**

Although no formal sessions of the Committee on National Emergency Medical Service have been held, the course outlined for development of the medical program in the last meeting of the State Civil Defense Medical Advisory Council, of which this Committee is the steering group, has been the course followed throughout the year now being reported upon.

It is felt that the footing of the medical program for Civil Defense has become considerably more firm in the State during this year. This has been brought into evidence as follows:

- (1) by the increased interest of groups of physicians in exploring and planning for their role in the Civil Defense program;
- (2) by the measures effected to vitalize the medical units already in existence;
- (3) by the impetus given towards developing a reservoir of emergency and reserve hospitals to complete the facilities for casualty care.

During the past six months two of the larger county medical societies of the State have devoted part of a monthly meeting to Civil Defense and one also to a full session on this subject. During this same period the professional staffs of three of the larger hospitals of the State have devoted staff sessions to the subject of Civil Defense and the Hospital Conference of the City of Baltimore has devoted two of its monthly meetings entirely to the subject of Civil Defense hospitalization. In addition, representatives of the profession in small groups or individually have assisted in a considerable number of Civil Defense conferences in the city and counties.

Although the number of casualty clearing stations in existence at the time of the last report (207) has been somewhat increased (212) and a large number of individuals have been added to these stations, the main emphasis during the year has been directed towards instilling into these units a knowledge of their function and an improvement in their technical effectiveness and unit esprit. On April 19, 1953, a Medical Policy Conference was conducted in Baltimore, attended by all Medical Civil Defense Directors and key personnel of medical units throughout the State. A panel of officials at this conference answered questions explaining the State's complete medical program and also the mission of individual units and the importance of their assuming individual activity.

Within the past few months training programs have been furnished to the heads of each of the casualty clearing stations and demonstration sets of equipment are being provided and training teams developed for each of the defense regions of the State. One hundred and fifty of the State's casualty clearing stations now have their full complement of initial equipment stored in the vicinity of the station sites.

Plans for patient evacuation and internal expansion have been prepared by the general hospitals in Anne Arundel,

* John M. Welch, M.D. (Col., USA, Ret.), Chief, Medical Services, Civil Defense, presented this report for Dr. Robert H. Riley.

Montgomery, Prince George's, Frederick, Cecil and Wicomico Counties. In these counties also buildings have been selected and staffs have been set up for 7 emergency hospitals in addition to the permanent hospitals. The personnel already assigned to these hospitals as their Civil Defense staff number 107 physicians, 326 nurses and 228 technical and other personnel.

Internal expansion and evacuation plans have also been prepared by all of the general and special hospitals in Baltimore City. Provision of emergency hospitals for the City, however, is being radically revised. The increased area of destructiveness to be expected from the larger calibre of atomic weapons has resulted in studies aimed toward the removal of emergency hospital sites from the center of the city to locations outside of the recalculated burst area. Increased casualty estimates have also resulted in plans for a greater number of emergency hospital units in appropriate buildings within this circular band of hospitalization on the outskirts of the city, extending into the surrounding counties. The equipments for these emergency hospitals are designed to solve the initial needs for casualty care during the first several hours of activity. Twenty of these initial equipments, each weighing twelve and a half tons, have been purchased by the State with matching Federal funds, and their delivery is now being awaited. Supplies to back up the needs for these hospitals after their first hours of operation would be furnished from the Federal warehouses serving this area.

In the latter part of June, 1953, the position of Chief of Medical Services, Civil Defense, under the Medical State Deputy was assumed by Dr. John M. Welch as successor to General Robert P. Williams (Ret.).

It is proposed that the House of Delegates approve the following recommendation to be sent to the President of each county and city Medical Society of the State:

In order that the physicians of the State may be kept abreast of current medical progress in Civil Defense and brought up to date relative to their expected role in this program, it is recommended that each of the local societies of this Faculty devote, wholly or in part, one of its scheduled meetings during the coming year to the subject of "The Medical Aspects of Civil Defense." (See page 411.)

Respectfully submitted,
 ROBERT H. RILEY, M.D., *Chairman*
 J. ALBERT CHATARD, M.D.
 ALAN M. CHESNEY, M.D.
 C. REID EDWARDS, M.D.
 CHARLES W. MAXSON, M.D.
 PERRY F. PRATHER, M.D.
 WALTER D. WISE, M.D.
 GEORGE H. YEAGER, M.D.
 MR. GEORGE BUCK
 MR. WALTER N. KIRKMAN

NEW BUILDING COMMITTEE

Mr. President and Members of the House of Delegates:

There is no formal report for this Committee. Dr. Goldstein has made a recommendation to the House of Delegates and I

think any future activity for the New Building Committee would depend on the ruling made by the House of Delegates.

Respectfully submitted,

C. REID EDWARDS, M.D., *General Chairman*
 ALBERT E. GOLDSTEIN, M.D., *Chairman, Finance Committee*
 JOHN W. PARSONS, M.D., *Treasurer, Finance Committee*
 R. WALTER GRAHAM, JR., M.D., *Chairman, Building Plans*
 HARRY C. HULL, M.D.
 I. RIDGEWAY TRIMBLE, M.D.

NEW BUILDING COMMITTEE— SUBCOMMITTEE ON FINANCE

Mr. President and Members of the House of Delegates:

The resolution which our Committee is presenting was forwarded to the Component Medical Societies and on instruction from the Council, referred to the Resolutions Committee.

In the beginning of this campaign, which I undertook with my Committee, it was definitely decided that if we did not raise the full amount for the purpose for which it was desired, that all monies would be returned to the respective donors. This would mean that we would have to return about \$80,000.00. To me, this would be a very sad thing to do, particularly when we are so desirous of going through with our remodeling and additions.

I want you to understand that I, as well as my Committee, are willing to continue solicitation of the different members, even though it has been, and will be, a very difficult procedure. It is also questionable in our mind whether we would collect the necessary amount of at least \$300,000.00. My Committee has felt that the only equitable way is to see that each and every member has some particular interest in the project, and that a few should not be compelled to care for the entire problem.

Suggestions from you will be appreciated.

Resolved, that whereas the Medical and Chirurgical Faculty Building of Maryland is in need of remodeling and additional space for meeting rooms and its library, together with the necessity of refurbishing and refurnishing its quarters, and whereas a number of the City and County Members have voluntarily pledged sums of money to the extent of approximately \$80,000 and, whereas an additional sum of money amounting to \$220,000 or more is necessary, be it resolved that an amount of money should be contributed in the form of an assessment by each member of the Medical and Chirurgical Faculty.

The assessment should be arranged in the following manner.

1. All members of the City and State Medical Society should be assessed an amount of \$150.
2. All members of the County and State Medical Society should be assessed an amount of \$100.

Members who have already pledged an amount equal to the above as the case may be should be exempt from any assessment excepting in those cases where the amount pledged is not equal to the above mentioned amounts, then assessments should be for only the difference.

Assessments should be made at the rate of \$10 per year until the full amount is paid. Should any member desire to pay

larger amounts in any one year he may have this privilege.
(See page 415.)

Respectfully submitted,
ALBERT E. GOLDSTEIN, M.D., *Chairman*
WARDE B. ALLAN, M.D.
JAMES G. ARNOLD, JR., M.D.
JOHN A. ASKIN, M.D.
WALTER A. BAETJER, M.D.
ALAN BERNSTEIN, M.D.
C. BERNARD BRACK, M.D.
LEO BRADY, M.D.
OTTO C. BRANTIGAN, M.D.
HENRY BRIELE, M.D.
WEBSTER H. BROWN, M.D.
EDWIN N. BROYLES, M.D.
WILLIAM D. CAMPBELL, M.D.
FERDINAND E. CHATARD, IV, M.D.
BEVERLEY C. COMPTON, M.D.
EDWARD W. DITTO, M.D.
LOUIS C. DOBHIAL, M.D.
LOUIS H. DOUGLASS, M.D.
MONTE EDWARDS, M.D.
W. R. FERGUSON, M.D.
WETHERBEE FORT, M.D.
FRANK J. GERAGHTY, M.D.
MARK E. GANN, M.D.
ROBERT W. GARIS, M.D.
LEWIS P. GUNDRY, M.D.
LOUIS P. HAMBURGER, SR., M.D.
H. HANFORD HOPKINS, M.D.
HARRY C. HULL, M.D.
J. MASON HUNDLEY, JR., M.D.
PAGE C. JETT, M.D.
HUGH J. JEWETT, M.D.
MARIUS P. JOHNSON, M.D.
JOHN T. KING, M.D.
E. PAUL KNOTTS, M.D.
LEON A. KOCHMAN, M.D.
GEORGE A. KOHLER, M.D.
AMOS R. KOONTZ, M.D.
EDWARD F. LEWISON, M.D.
E. T. LISANSKY, M.D.
HELEN I. MAGINNIS, M.D.
W. KENNETH MANSFIELD, M.D.
ERWIN E. MAYER, M.D.
KARL F. MECH, M.D.
VICTOR D. MILLER, M.D.
WALDO B. MOYERS, M.D.
W. RAYMOND MCKENZIE, M.D.
SAMUEL McLANAHAN, M.D.
EMIL NOVAK, M.D.
FRANK J. OTENASEK, M.D.
DANIEL J. PESSAGNO, M.D.
ESTHER L. RICHARDS, M.D.
HARRY M. ROBINSON, JR., M.D.
FRED B. SMITH, M.D.
HOWARD C. SMITH, M.D.

RICHARD W. TELINDE, M.D.
EDWARD P. THOMAS, M.D.
RAYMOND K. THOMPSON, M.D.
W. HOUSTON TOULSON, M.D.
I. RIDGEWAY TRIMBLE, M.D.
HENRY F. ULLRICH, M.D.
GRANT E. WARD, M.D.
LAWRENCE R. WHARTON, M.D.
W. L. WINKENWERDER, M.D.
WALTER D. WISE, M.D.
HENRY L. WOLLENWEBER, M.D.
AUSTIN H. WOOD, M.D.
JAMES D. WOODRUFF, M.D.
ALAN C. WOODS, M.D.
PEREGRINE WROTH, M.D.
ISRAEL S. ZINBERG, M.D.

New Building Committee Subcommittee on Building Plans

Mr. President and Members of the House of Delegates:

There has been no further activity as far as the Building Plans Committee is concerned. Some money is still being collected by Dr. Goldstein, but we are far from a sum sufficient to take any definite action on a new building at this time.

Respectfully submitted,
R. WALTER GRAHAM, JR., M.D., *Chairman*

COMMITTEE FOR THE STUDY OF PELVIC CANCER

Mr. President and Members of the House of Delegates:

Fifteen hospitals in Baltimore City are cooperating with the Committee for the Study of Pelvic Cancer in its review of pelvic cancer cases. As of March 1, 1954, the study has included six hundred and two cases which have been treated in these hospitals. The cases have been reviewed and classified according to the delay period between the time of onset of symptoms and the time of correct diagnosis and adequate treatment. We have considered a time lapse of more than one month as delay. The cases have been classified as follows:

Patient Delay.....	269	44.7%	} 20.1%
Physician Delay.....	55	9.1%	
Physician and Patient Delay.....	30	5.0%	
Institutional Delay.....	18	3.0%	
Institutional and Patient Delay.....	13	2.2%	
Institutional and Physician Delay.....	3	.5%	}
Institutional, Physician and Patient Delay.....	2	.3%	
No Delay.....	192	31.9%	
Asymptomatic Detected Cases.....	20	3.3%	

The Committee meets on the third Thursday of each month. Selected cases are presented and discussed at these meetings. All doctors concerned in the treatment of a case are invited to attend. We hope that these informal discussions of

the problems met in the diagnosis and treatment of pelvic cancer will be of benefit to all physicians.

Respectfully submitted,

RICHARD W. TELINDE, M.D., *Chairman*
J. MASON HUNDLEY, JR., M.D., *Vice-Chairman*
BEVERLEY C. COMPTON, M.D., *Secretary-Treasurer*
C. BERNARD BRACK, M.D.
CHARLES N. DAVIDSON, M.D.
EVERETT S. DIGGS, M.D.
FREDERICK D. DOVE, M.D.
HOWARD W. JONES, JR., M.D.
THEODORE KARDASH, M.D.
EMIL NOVAK, M.D.
MARK V. ZIEGLER, M.D.

PHYSIOTHERAPY COMMITTEE

Mr. President and Members of the House of Delegates:

Report on the Physiotherapy Committee is negative.

Respectfully submitted,

W. RICHARD FERGUSON, M.D., *Chairman*
JOHN J. DOBBIE, M.D.
MOSES GELLMAN, M.D.
H. ALVAN JONES, M.D.
HOWARD F. KINNAMON, M.D.
C. ARTHUR ROSSBERG, M.D.
ALLEN F. VOSHELL, M.D.

POSTGRADUATE EDUCATIONAL COMMITTEE

Mr. President and Members of the House of Delegates:

The Postgraduate Educational Committee held no meeting and has no report to submit.

Respectfully submitted,

EDWARD S. STAFFORD, M.D., *Chairman* (1953)

PROFESSIONAL CONDUCT COMMITTEE

Mr. President and Members of the House of Delegates:

This Committee has had no occasion to hold a conference. There have been frequent complaints, mostly concerning professional charges. These were all of minor importance, and your Chairman did not feel justified in calling meetings to discuss these difficulties.

Your Chairman has frequently consulted with members of the Committee and with the Secretary. In all instances the complaints have been adjusted, we hope, satisfactorily to the complainant and the physician.

The only major difficulty was a complaint concerning a request by a complainant for an itemized hospital bill. This was finally obtained and surveyed, with a recommendation that the hospital contact the complainant and adjust the difficulty. This has been done.

I believe that this Committee is worthwhile, and doing the community as well as the profession, a real service.

Respectfully submitted,

CHARLES W. MAXSON, M.D., *Chairman*, 1953

Mr. President and Members of the House of Delegates:

The Professional Conduct Committee has reviewed approximately thirty-five complaints during the past year.

The attention of the membership is called to the fact that the Professional Conduct Committee tries its best to adjust these grievances between the doctor and patient in order to avoid any serious consequences. Since the action of the Professional Conduct Committee is always on file at the Faculty office, it enables the Council to better decide the merits of the cases that come to suit.

Respectfully submitted,

W. HOUSTON TOULSON, M.D., *Past President* (1949),
Chairman, 1954

A. AUSTIN PEARRE, M.D., *Past President* (1950)

WALTER D. WISE, M.D., *Past President* (1951)

ALAN M. CHESNEY, M.D., *Past President* (1952)

MAURICE C. PINCOFFS, M.D., *Past President* (1953)

E. COWLES ANDRUS, M.D., *Chairman of Council*

COMMITTEE ON PUBLIC INSTRUCTION

Mr. President and Members of the House of Delegates:

A review of Maryland's health record for 1953 compared with 1952 indicate a number of outstanding advances in the state's health status. Among these are: A remarkable and significant decline of 35 per cent in the total tuberculosis death rate and a drop of 44 per cent in the Negro tuberculosis death rate. In Baltimore City a calendar year passed without a diphtheria death; there was further progress in the control of syphilis; a virtual eradication of death due to the common communicable diseases; and the reduction of maternal deaths to a position where this record approaches an irreducible low figure. While it is apparent that no one factor can be responsible for these improvements it may be said that much was contingent upon the educational experiences of both physicians and the lay public provided by the Medical and Chirurgical Faculty and associated health agencies.

Particular programs to which the Medical Faculty gave strong support and to which its Committee on Public Instruction devoted its efforts were: The County and City Medical Care Programs; the continuing chronic illness door-to-door study by the National Commission on Chronic Illness; public instruction regarding the use and limitations of gamma globulin in relation to poliomyelitis; the city-wide Diabetes and Tuberculosis Survey in November, 1953 during which more than 6,000 persons were tested; the Exhibition on the History of Medicine in Maryland: 1634-1953 presented at the Maryland Historical Society from November 16th to the end of the year and which dealt with Medical Education and Research, General Practice, Hospitals, Public Health, Nursing, Dentistry and Pharmacy; and the continuing weekly radio and television series.

The regular weekly radio and television series sponsored jointly with the Baltimore City Health Department have proven an important community health education venture. These programs are guided by Faculty members who are frequently called upon to participate in the television series. Reports from radio station WFBR indicate that the "Keeping Well" series in which Dr. Nels A. Nelson, Director of the City Health Department's Bureau of Venereal Diseases portrays a family physician is well attended with a slightly higher rating in 1953 than in 1952. Although actual listening figures are lacking, the program rating compares favorably with top network productions. The weekly radio series has been broadcast continually since 1932 when a five minute health talk series was begun. It has been presented in its present form as a health drama since 1939.

The television series was inaugurated in December, 1948. A total of two hundred and sixty 15 minute programs have been presented through December, 1953. Audience participation in the Baltimore area alone reached as high a number as 100,000 persons. Mr. Robert Keller of the City Health Department's Civil Defense Health Service staff continues to portray the family doctor, Dr. John Worthington. One of the highest tributes to this program was an editorial in a local newspaper which quoted Senator John M. Butler on education by television . . . "Station WMAR-TV has likewise given much time for educational purposes. Many of these highly effective programs have been conducted in collaboration with educational institutions. To my mind, its 'Family Doctor' series, which has been on the air for a long time, is one of the most instructive programs for adult listening carried in Baltimore." An extensive correspondence with other health groups has developed as a result of these programs. A large percentage of letters request further information regarding program production.

The exhibit "Lead Poisoning in Children" prepared in 1952 and designed for the medical profession and health agencies was displayed upon request at the Fifth Annual Meeting of the American Academy of General Practice in St. Louis in March, 1953. Numerous other health exhibits were prepared and set up in clinics and other public places throughout the state.

In conclusion it may be stated that the Committee on Public Instruction continues its activities with the help of the State, County and City Health Departments as a part of their work directly and indirectly with members of the medical profession and the general public. Records of these latter activities may be found in the periodic health department reports, their bulletins, publications and press releases.

Respectfully submitted,

HUNTINGTON WILLIAMS, M.D., *Chairman*
E. I. BAUMGARTNER, M.D.
PAGE C. JETT, M.D.
WILLIAM D. NOBLE, M.D.
ROBERT H. RILEY, M.D.
PETER P. RODMAN, M.D.
A. F. WHITSITT, M.D.
FRANK D. WORTHINGTON, M.D.

COMMITTEE TO CONSIDER THE RELATIONSHIP BETWEEN HOSPITALS AND SPECIALTIES AND THE MANNER OF PAYMENT FOR PROFESSIONAL SERVICES

Mr. President and Members of the House of Delegates:

This Committee has had no disputes referred to it by either professional personnel or hospitals during the present year.

While it is true that this has been a very inactive Committee, it does provide the mechanism for handling certain situations which might arise at any time. As far as I know, there are no pending cases.

The Maryland State Radiological Society has appointed a Committee and supplied some funds for an investigation of Radiological equipment in this area under the control of physicians, hospitals, federal agencies, etc. An integral portion of that investigation will be a questionnaire as to working conditions and complaints of Radiologists. It is possible that some inequitable conditions may arise from the investigation and be brought under consideration.

Respectfully submitted,

WEBSTER H. BROWN, M.D., *Chairman*
E. HOLLISTER DAVIS, M.D.
MERRELL L. STOUT, M.D.
HENRY L. WOLLENWEBER, M.D.
MR. GEORGE H. BUCK
MR. PARKER J. McMILLIN
MR. HARVEY H. WEISS

REPORT OF RESOLUTIONS COMMITTEE

See minutes of the House of Delegates, Monday, April 26, 1954, pages 410-413.

ROBERT V. CAMPBELL, M.D., *Chairman*
CHARLES R. AUSTRIAN, M.D.
WHITMER B. FIROR, M.D.
I. RIVERS HANSON, M.D.
M. C. PORTERFIELD, M.D.

COMMITTEE ON RURAL MEDICINE

Mr. President and Members of the House of Delegates:

The Committee on Rural Medicine did not have a formal meeting this year due to the fact that previous attempts at meetings, with a committee of such necessarily scattered membership, have proved discouraging and indicated lack of feasibility. Therefore, the business of the committee has been carried on largely by personal contact with members of the committee and correspondence.

Our first problem was a request to aid in the placement of a physician in Western Maryland. Inquiry into the matter showed that there really was no justification for placing a physician in this location simply because there had been a physician there previously, and the son of the physician, who had died, felt that the community could hardly support a

physician since there were two other physicians within seven miles.

The shortage of physicians in rural areas, however, still represents an unmet need. Though not as acute as it was in the past, nevertheless, there is not a county in Maryland which could not very well support another general practitioner and at least one or two men in specialties.

Mr. Dabney of the Blue Cross has indicated that there will be a policy available for farm people this year. While one out of three of the residents of Maryland have Blue Cross, when one divides that into urban and rural ratio, we find that in the rural area, it was one out of seven. It is hoped that this new policy will obviate the necessity of farm families entering into a group, as experience with the Farm Bureau and other groups has been somewhat unsatisfactory.

The Hill-Burton hospital building program continues satisfactorily.

The Committee must report that the problem of securing interns for rural hospitals over 100 beds received a set-back this year. It was found, first, that the interns complained of the amount of work that they were permitted to do and secondly, that they received little or no instruction.

Your chairman lectured for the students at the University of Maryland on March 10, on the subject of "Starting Out in Practice," which, in reality, was an invitation to locate in a rural area.

Respectfully submitted,

PAGE C. JETT, M.D., *Chairman*
 MORRIS FRANKLIN BIRELY, M.D.
 ARTHUR TALBOT BRICE, M.D.
 THOMAS A. CHRISTENSEN, M.D.
 LOUIS H. DOUGLASS, M.D.
 JOHN FAWCETT, M.D.
 J. STANLEY GRABILL, M.D.
 JOHN H. GRIFFIN, M.D.
 JAMES W. MEADE, JR., M.D.
 HAROLD B. PLUMMER, M.D.
 ERNEST S. POOLE, M.D.
 PERRY F. PRATHER, M.D.
 WALTER H. SHEALY, M.D.
 H. J. SLUSHER, M.D.
 MILFORD H. SPRECHER, M.D.
 HUGH W. WARD, M.D.

SCIENTIFIC SPEAKERS BUREAU

Mr. President and Members of the House of Delegates:

There have been very few requests sent into the Scientific Speakers Bureau during this past year.

Dr. Everett S. Diggs, the newly elected Secretary of the Medical and Chirurgical Faculty reactivated an old custom by having a meeting of the Secretaries of the Component Societies. I would like, at this time, to express my appreciation to Dr. Diggs for having held this meeting prior to Annual Meeting so that there would be no conflict with the scientific sessions. At this meeting, the Secretaries stated that they had found the list of speakers most helpful when arranging their Medical Society Meetings, and requested that a revised list be made available.

It would be appreciated if the delegates would bring to the attention of their Component Medical Societies this request, and submit to me subjects, which they would like to have presented to their local Society. We will then compile a new list of subjects and speakers, and send them to our Component Medical Societies. However, if this work of the Scientific Speakers Bureau is to be of any value to the Component Societies, the only way to show it, is to use the facilities as provided by our Committee.

Respectfully submitted,

BEVERLEY C. COMPTON, M.D., *Chairman*
 ALAN M. CHESNEY, M.D.
 I. RIDGEWAY TRIMBLE, M.D.
 THEODORE E. WOODWARD, M.D.
 H. BOYD WYLIE, M.D., *ex officio*

COMMITTEE TO ADVISE THE STATE DEPARTMENT OF HEALTH

Mr. President and Members of the House of Delegates:

Your Committee to Advise the State Department of Health has not held a meeting since its last report since no questions have been submitted by the Department to the Faculty during that period.

Respectfully submitted,

ALAN M. CHESNEY, M.D., *Chairman*
 EVERETT S. DIGGS, M.D.
 BENDER B. KNEISLEY, M.D.
 GEORGE H. YEAGER, M.D.
 E. PAUL KNOTTS, M.D.
 GERALD W. LEVAN, M.D.
 ROBERT S. MCCENEY, M.D.
 MAURICE C. PINCOFFS, M.D.
 CHARLES H. WILLIAMS, M.D.

ADVISORY COMMITTEE TO THE STATE ACCIDENT FUND

Mr. President and Members of the House of Delegates:

The Committee has had but one occasion to be of any help to the Commission during the past year. The newly elected Chairman to the State Accident Fund has requested that this Committee recommend a Medical Advisor to the Accident Fund.

The Committee has met three times, and has made a recommendation that we trust will be satisfactory to the Fund and to the Medical Profession of the State, as a whole.

Respectfully submitted,

CHARLES W. MAXSON, M.D., *Chairman*
 AMOS R. KOONTZ, M.D., *Vice-Chairman*
 WILLIAM J. COLEMAN, M.D.
 GEORGE O. EATON, M.D.
 WILLIAM R. GERAGHTY, M.D.
 DONALD B. GROVE, M.D.
 HOWARD M. KERN, M.D.
 JAMES W. NELSON, M.D.
 S. JACK SUGAR, M.D.
 EDWARD P. THOMAS, M.D.

TUBERCULOSIS COMMITTEE

Mr. President and Members of the House of Delegates:

The Tuberculosis Committee met four times during February-March 1954 to discuss problems associated with care of tuberculosis patients in Maryland.

1. *It is recommended that there be equal opportunity for participation by our two medical schools in the total program of the State Tuberculosis Hospitals including medical and surgical aspects.*

2. *It is recommended that a study be made of possibilities for surgical resident physicians of interested State general hospitals to obtain training in thoracic surgery at Mt. Wilson Hospital, Chest Surgical Center of State Tuberculosis Hospitals.*

3. In 1953 this Committee reported 304 persons awaiting hospitalization in mid March. At the same period in 1954 there were about 160 persons on waiting lists. Practically all of these were negroes, mostly from Baltimore City. Opening of units of Mt. Wilson and Baltimore City Hospitals have been helpful. Surgical divisions of these hospitals expect to open soon.

White persons can obtain almost immediate hospitalization at State or Baltimore City Hospitals. Negro hospitalization, at present, is limited to Henryton or Baltimore City Hospitals.

It is recommended that hospital beds in all tuberculosis hospitals of the State be available to patients regardless of color. This will promote rapid abolition of our waiting lists.

4. Cases of "open" tuberculosis who refuse isolation create a serious problem. It is recommended that there be a consideration for legal regulations concerning treatment and hospitalization of cases of tuberculosis who are in a communicable state and considered a "public menace."

5. *It is recommended that there be routine chest x-rays of all hospital and institutional admissions. Extension of present case-finding procedures should be encouraged.*

6. Attention is called to the fact that private sanatoria handling tuberculosis patients may be handicapped by present application of a "means" test. It is felt that an evaluation is in order with probable elevation of minimum income requirements before patient supplementation is necessary.

7. There have been comments concerning unsatisfactory chest clinic-physician arrangements on follow-up procedures of patients reporting for clinic x-rays.

In Baltimore County, chest clinics send letters of notification including x-ray interpretation to the patients' physician. The physician is asked whether he intends to give complete follow-up care to the patient; have the clinic take complete charge; or have the clinic do a certain part of further examination. If the patient does not designate a physician, he is offered a list of physicians in his locality from which to choose. This system has had favorable comment from physicians, clinics, and patients.

It is recommended that a similar pattern be urged for other component units of the society to include arrangements with clinics of Baltimore City Health Department, Maryland State Health Department, as well as those of the Maryland Tuberculosis Association.

8. It is gratifying to report that tuberculosis mortality

in the State continues to decrease with 436 deaths in 1953 as against 637 in 1952. Provisional U.S. Mortality in 1952 was 16.1 per 100,000 population; that in Maryland in 1953 17.5 per 100,000.

New cases, however, decreased only about 10% during 1953 with 1,748 new cases being reported throughout Maryland (See pages 411-412.)

Respectfully submitted,

LAWRENCE M. SERRA, M.D., *Chairman*

EDMUND G. BEACHAM, M.D.

OTTO C. BRANTIGAN, M.D.

LEON H. HETHERINGTON, M.D.

H. VERNON LANGEUTTIG, M.D.

ISADORE B. LYON, M.D.

JOHN E. MILLER, M.D.

HUGH G. WHITEHEAD, JR., M.D.

SAMUEL WOLMAN, M.D.

COMMITTEE ON VETERANS' MEDICAL CARE

Mr. President and Members of the House of Delegates:

A special regional meeting was called in Washington on Sunday, November 15, 1953, by Dr. Louis M. Orr, Chairman of the National Committee on Medical Care of Veterans of the American Medical Association. Every Component Medical Society was contacted by letter and asked to appoint someone or go themselves to this meeting. The following members from the Medical and Chirurgical Faculty attended: James E. Andrews, Charles County; S. Ralph Andrews, Cecil County; Raymond M. Curtis, Baltimore City; Amos R. Koontz, Baltimore City; Frank E. Mason, Talbot County; Mitchell H. Miller, Baltimore City; Waldo B. Moyers, Prince George's County; Richard C. Norment, III, Harford County; John W. Parsons (AMA delegate), Baltimore City; Robert Pilgram, Frederick County; Theodor Sattelmair, Queen Anne's County; Charles H. Williams, Baltimore County; and Richard Williams, Allegany-Garrett County.

Many facts concerning the Veterans Administration were brought out at this meeting, and I am sure a great deal was accomplished.

Your Committee on Veterans' Medical Care has also written letters to the various Presidents of the Component Medical Societies, requesting that a representative be appointed to serve in conjunction with your State Medical Society Committee on dissemination of facts concerning the Veterans Administration. So far the following have been appointed by their respective Presidents, and we hope to hear from the others: Thomas E. Wheeler, Baltimore County; Robert Pilgram, Frederick County; Merrill M. Cross, Montgomery County; Waldo B. Moyers, Prince George's County; Theodor Sattelmair, Queen Anne's County; C. G. Rawley, Somerset County; Howard F. Kinnamon, Talbot County; Wilbur R. Ellis, Wicomico County.

We have forwarded the American Medical Association "Information Kits" to these representatives, as well as to the Component Society Presidents who have, up to date, not sent in the names of their local representatives.

Dr. R. Walter Graham gave a stirring talk to the Baltimore

County Medical Society at the Stafford Hotel on March 17, clearly outlining the threat of Socialized Medicine inherent in the expansion of the Veterans Administration.

The American Medical Association proposes that the Veterans Administration treat only service-connected disabilities and non-service connected disabilities due to Tuberculosis and Psychiatric disorders.

There are six categories of non-service connected disabilities that would be eliminated from Veterans Care.

There is considerable disagreement in the State Societies about these categories. Your Committee, except the Chairman, agree with the A.M.A. that they should be eliminated.

Your Chairman feels that after thirty years or more, it would not be well to eliminate these categories, as it creates increasing organized resistance to our proposition.

Your Chairman feels that the real danger of the Veterans Administration expanding, lies in glossing over or eliminating the financial responsibility clause. If this were eliminated, 21 million veterans would be eligible. If this occurred, wives and children would even be included. Collective Medicine would be a fact.

Under the attack of the A.M.A. the Veterans Administration has greatly enlarged the financial responsibility clause, in that misrepresentation of financial facts constitute perjury, and is subject to prosecution.

In the April 10 Journal of the American Medical Association the A.M.A. Committee now advocates no new legislation until the effect of the new Financial Responsibility Clause is observed.

The Tennessee Plan proposes to use Federal Income Tax Returns to determine financial status. Then if the veteran is eligible he is to be treated in a Civilian Hospital at Government expense instead of in a U. S. Hospital. Then further expansion of the Veterans Administration would not be necessary.

Your Committee feels that progress is being made.

Respectfully submitted,

RALPH G. HILLS, M.D., *Chairman*

ERNEST I. CORNBROOKS, JR., M.D.

RAYMOND M. CURTIS, M.D.

R. WALTER GRAHAM, JR., M.D.

HARRY C. HULL, M.D.

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

Mr. President and Members of the House of Delegates:

During the past year, the Committee has stood by to be of help when requested by the officers of the Woman's Auxiliary. On several occasions matters have arisen upon which advice has been sought and through the chairman advice has been given, either verbally or in writing. No matters affecting major policies as far as the Faculty is concerned have come up.

Respectfully submitted,

SAMUEL McLANAHAN, M.D., *Chairman*

WILLIAM K. DIEHL, M.D.

WILLIAM D. NOBLE, M.D.

COMMITTEE FOR BETTER DISTRIBUTION OF DOCTORS THROUGHOUT THE STATE

Mr. President and Members of the House of Delegates:

Although the above Committee has made no active steps in regard to the implications of its name, the Chairman has conferred with the American Medical Association and has obtained available data from its Bureau of Medical Economic Research, with Dr. H. B. Mulholland, originator of the program in Virginia, and with the Dean of the University of Maryland Medical School. The Chairman has also obtained literature from the American Medical Association and a number of States which have services for better distribution of doctors.

A definition of a good physician placement service is given by the director of the Virginia Council on Health and Medical Care:—

"By a good service, I mean one where requests from communities are carefully investigated to establish the need for a doctor; where there is a personnel available to meet with community groups to give them the ABC's of getting doctors; where up-to-date information is sent monthly or at least quarterly to communities on available doctors and detailed information to doctors on communities; where periodic follow-up visits are made to communities to encourage them and answer questions, and where contact is kept with the community and the local doctor to make certain that the new relationship is not spoiled by misunderstandings, and that the doctor, once located, stays."

It is noted that in every state studied, there is an individual assigned to carry out the investigations and responsibilities incident to the necessary activities as much office and field work is essential to the duties of a Committee for Better Distribution of Doctors. Much data must be assembled and analyzed including the files from the Medical Advisory Committee to Selective Service under Dr. Walter Graham.

As it has become increasingly evident that no practising physician can possibly give the time and energy necessary to develop the facts vital to this Committee, nor can one such carry on the activities incident to the certain outgrowth of same, the Chairman of your Committee suggests the following three recommendations:—

- 1) *That some person in the executive or administrative branch of the Faculty be assigned (or employed) to act as Director of the services incident to the Committee.*
- 2) *That the Committee for the Better Distribution of Doctors in the State of Maryland be assigned to an Advisory status for the Director.*
- 3) *That sufficient funds be budgeted to carry out the proper and necessary functions of the above services.*

Respectfully submitted,

ALLEN F. VOSHELL, M.D., *Chairman*

E. I. BAUMGARTNER, M.D.

A. M. FRANCE, M.D.

I. RIVERS HANSON, M.D.

RICHARD T. SHACKELFORD, M.D.

SPECIAL COMMITTEE IN REGARD TO DUES OF ACADEMIC PHYSICIANS

Mr. President and Members of the House of Delegates:

As a result of the action of this body at its October, 1953, meeting, Dr. Maurice C. Pincoffs, the President, appointed our Committee on November 3, 1953, to make a study and recommendations regarding Chapter II, Section 1-(d) of the By-Laws of the Medical and Chirurgical Faculty.

The By-Law reads at present:

The dues of a licensed physician in Maryland who holds an academic position on a full time salary basis, other than as a fellow or a house officer, shall be \$15.00 per annum during the first five years of his academic position.

It is proposed that this section be amended to read as follows:

The dues of a licensed physician in Maryland who holds an academic position on a strict full time salary basis, other than as a fellow or house officer, shall be \$10.00 per annum as long as he holds a rank below that of an Associate Professor. (See page 414.)

Justifications: With rare exceptions, the maximum professional income of a full time teacher referred to in this section, as amended is \$8,500; the salaries of many are considerably less than this figure. These men graduated from medical school five years or more ago. Some of these young men remain in full time academic positions for the full course of their professional careers; hence, the maximum income to which they can look forward is not as high as that of many men engaged predominantly in private practice.

Our suggested specification of the specific rank below "Associate Professor" clears up former ambiguity implicit in "during the first five years of his academic position."

Twenty members of the clinical faculty at Hopkins and nine at Maryland fall into the category covered by the amendment. Twenty-two of the twenty-nine now hold some form of membership in the State Society.

Thus the group involved is small, relative to the total membership of 2600 in the State Society. It is important that the Faculty assure participation by these men in the activities of their Medical Society. This group contributes to the state and local societies by participation in their meetings, where they present data on recent advances in scientific medicine. Further, since these men are active teachers, it is important that their liaison with the problems of a wide group of practitioners be close. Encouragement of membership in the societies and participation in their various activities will promote this liaison.

The proposed dues are nominal, being \$10.00 for the men in this category. The balance between this amount and the full dues will actually be contributed by the much larger group of members of the State Society, who pay full dues. It is contemplated that the members of the Society will appreciate that, in offering this group of teachers full membership for \$10.00, they are in fact, making a contribution to the State's two medical schools. For, by maintaining the dues at a nominal level, they will contribute to maintaining the personal

professional expenses of this group of young men at a low level, thereby rendering more attractive to young men these important teaching positions in the schools and assisting the recruitment of men for these positions.

Respectfully submitted,

PALMER H. FUTCHER, M.D., *Chairman*

GORDON E. GIBBS, M.D.

ROBERT T. PARKER, M.D.

EDWARD S. STAFFORD, M.D.

COMMITTEE FOR THE STUDY OF CERTAIN PHASES OF MEDICAL ECONOMICS

Mr. President and Members of the House of Delegates:

No report. (See pages 412-413.)

Respectfully submitted,

WALDO B. MOYERS, M.D., *Chairman*

WOLCOTT L. ETIENNE, M.D.

HOUSTON S. EVERETT, M.D.

THOMAS K. GALVIN, M.D.

FRANK J. OTENASEK, M.D.

COMMITTEE TO STUDY AVAILABILITY OF PREPAYMENT INSURANCE IN RURAL AREAS

Mr. President and Members of the House of Delegates:

The information which is desired involves a complete survey and study of prepayment insurance coverage of Hospital, Accident and Health Insurance, so it has been impossible to obtain this information in time for presentation at the Spring Meeting of the Faculty.

I might say that I recently attended a meeting in New York and listened to a Symposium on this subject, sponsored by the Association of Life Insurance Medical Directors of America.

At this meeting many of the topics mentioned in your letter were discussed, such as coverage of individuals not eligible for Blue Cross and Blue Shield and other forms of group insurance.

It was also emphasized at this meeting that many of the contracts offered by some of the Health, Accident and Casualty Companies containing exclusion clauses, riders and restrictions have confused the public and that the many lengthy miscellaneous forms, which have to be completed by doctors, have become quite annoying to the profession.

The life insurance companies are now taking a very active part in trying to correct these irregularities and thereby bring about better public and professional relationships.

At the present time, there are fifty large insurance companies now underwriting health insurance with premiums amounting to three billion dollars annually. This is an increase of 24% over the past year.

There are also more than 800 different companies, not including the life companies, writing some form of health insurance. Naturally, with so many companies involved,

writing all types of coverage, you can readily understand the reason for such confusion.

It is, therefore, quite obvious to the medical directors of life insurance companies that not only the public has been taken advantage of, but also the medical profession; hence, the numerous "squawks" from both sources, and their desire to correct it.

It is estimated that 60 out of every 100 workers carry some form of health insurance and that 38 million have loss of earning policies, of which 75% of this group was written by life insurance companies.

In order to show how rapidly this form of insurance is pyramiding, by the end of September, 1952, which is the latest report I have, there were 91,667,000 who had some form of health policies.

Some companies, who are trying to simplify the subject, are now writing a combined package policy on a one premium basis.

1. Life and Retirement Insurance
2. Temporary Disability Coverage
3. Hospital, Medical and Surgical Care
4. Catastrophic Insurance

It may also be worth mentioning that some companies are now considering substandard health insurance for those impaired individuals not eligible for standard insurance.

From these few remarks you can readily see how greatly involved we all are in trying to get an adequate solution to voluntary health insurance.

The life insurance companies realize their responsibility in this field and fully recognize the many problems that now exist and need correction.

I think you may all agree that the future of insurance medicine depends upon the cooperation of the medical profession which must eventually be geared to voluntary life, hospital, health and accident insurance plans.

Life insurance companies have now taken a very definite step in this direction having created a Life Insurance Medical Research Fund amounting to five and a half million dollars for two hundred research programs in our medical schools for the study of cardio-vascular diseases.

Just recently the Life Insurance Association of America and the American Life Convention appropriated \$200,000.00 with a full time director, Mr. James Andrews, and a staff to set up an organization consisting of the following groups:

1. Survey Committee
2. Doctors Committee
3. Medical Liaison Committee
4. Educational Committee

5. Life and Casualty Insurance Committee
6. Claims Committee
7. Hospital Committee
8. Industrial Committee
9. Top Business Management Committee

The purpose of this group is to study the various phases of prepaid insurance at the Federal, State and City levels.

These groups are also to consider all proposed legislation introduced in Congress on the various bills aimed to provide government sponsored insurance and subsidies for accident, health and hospitalization.

The Administration sponsored bills as a part of the National Health Program are appropriately directed toward encouraging the stimulating insurance companies and other non-government organizations to provide better and cheaper health insurance services and wider coverage for the American public.

This objective is fully in keeping with the desires of the companies as well as the medical profession. However, we all must be aware of the fact that many of the advocates of the Murray Wagner Dingle boys are still with us.

The life insurance organizations plan to be ready to submit their views and suggestions to Congress during the coming committee hearings which are to be held on this subject.

Inasmuch as the life insurance companies, with all their financial resources and facilities, are now undertaking a complete study of this subject, I would advise you to await the outcome of this study.

As I am a member of this committee and expect to attend a meeting of this group in June, may I recommend for your consideration that the Faculty Committee be continued so that a more intelligent report could be submitted at the next meeting.

Maryland Hospital Service (Blue Cross) and Maryland Medical Service (Blue Shield) propose to offer shortly an enrollment program on a non-group basis. This matter has been approved by the Boards of both Organizations, and is now before the State Insurance Department. Public announcement will be made following their approval.

It is planned to offer this type of enrollment to persons in good health who are self-employed, not employed, or employed where there are less than five employees, and under 65 years of age. The contracts will be somewhat more limited as compared with the standard group contract.

Respectfully submitted,
 GEORGE McLEAN, M.D., *Chairman*
 HENRY BRIELE, M.D.
 ROBERT P. CONRAD, M.D.

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, July 2-29, 1954

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS
																			Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County.....	3	—	3	—	28	—	23	1	1	—	4	1	—	4	17	1	6	—	2
Anne Arundel.....	—	—	—	1	17	—	3	1	1	—	—	—	—	4	8	—	1	—	1
Howard.....	—	—	—	—	1	—	—	—	—	—	—	—	—	3	2	—	2	—	1
Harford.....	2	—	—	6	19	—	—	—	—	—	1	—	—	—	1	—	—	—	—
Carroll.....	1	—	—	1	7	—	—	1	—	—	9	—	—	3	—	—	1	—	1
Frederick.....	6	—	—	17	19	—	2	1	—	2	2	1	—	1	1	—	9	—	—
Washington.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	1
Allegany.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—
Garrett.....	—	—	—	1	1	—	—	—	—	—	—	—	—	—	1	—	—	t-1	—
Montgomery.....	5	—	2	—	43	1	9	—	2	1	3	—	1	4	11	—	3	—	3
Prince George's.....	2	—	2	1	19	—	9	1	—	—	—	—	—	2	4	—	2	—	1
Calvert.....	—	—	—	1	2	—	—	1	1	—	—	—	—	—	—	—	—	—	—
Charles.....	—	—	—	—	—	—	1	1	—	—	—	—	—	—	2	—	1	—	—
Saint Mary's.....	—	—	—	1	9	—	2	—	—	—	—	—	—	9	1	—	—	—	1
Cecil.....	1	—	—	3	6	—	1	—	—	—	—	—	—	—	1	—	—	—	—
Kent.....	—	—	—	3	16	—	3	—	—	1	—	—	—	1	—	—	—	—	—
Queen Anne's.....	—	—	—	4	—	—	1	—	—	—	—	—	—	1	2	—	1	—	—
Caroline.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—
Talbot.....	—	—	—	—	—	—	—	—	—	—	—	—	—	4	—	1	3	—	—
Dorchester.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3
Wicomico.....	—	—	1	—	2	—	6	1	—	—	2	—	—	—	3	1	23	—	—
Worcester.....	—	—	—	—	4	—	1	—	—	—	—	—	—	3	—	—	—	—	1
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	8	—	—
Total Counties.....	20	0	8	39	193	1	61	7	5	4	21	2	1	39	57	4	63		15
Baltimore City.....	45	1	9	1	48	1	62	2	0	0	9	2	0	56	109	13	626		11
State																			
July 2-29, 1954.....	65	1	17	40	241	2	123	9	5	4	30	4	1	95	166	17	689		26
Same period 1953.....	25	0	15	33	89	3	232	37	44	8	25	3	2	52	184	11	628		41
5-year median.....	75	1	25	—	105	2	118	19		14	22	3	3	63	223	26	668		24
Cumulative totals																			
State																			
Year 1954 to date.....	2950	10	271	641	11295	26	2626	15	6	16	1252	11	4	521	1296	102	4245		344
Same period 1953.....	2685	8	1402	300	1422	58	2047	49	46	11	2157	13	8	175	1431	91	4584		501
5-year median.....	2998	20	923	—	4125	39	1419	31		29	844	16	23	306	1657	269	4094		387

t = tetanus.

COMING MEETINGS

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty.

RICHARD W. TELINDE, M.D., *Chairman*

BEVERLEY C. COMPTON, M.D., *Secretary*

1211 Cathedral Street, Baltimore

Thursday, September 16, 1954, 5:00 to 6:00 p.m.

SECTION ON INTERNAL MEDICINE

FRANCIS W. GLUCK, M.D., *Chairman*

Tuesday, September 21, 1954, 8 p.m.

Faculty Building, 1211 Cathedral Street

Quarterly meeting.

MATERNAL MORTALITY COMMITTEE

1211 Cathedral Street, Baltimore

Thursday, September 23, 1954, 4:00 to 5:00 p.m.

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the Baltimore City Health Department.

CIVIL DEFENSE STOCKPILING 200-BED PORTABLE HOSPITAL UNITS

The AMA Washington Letter, No. 72

As part of its emergency medical supply stockpiling program, Federal Civil Defense Administration has ordered 200 portable hospital units of 200-bed capacity, and another 90 are on order for states and cities under the matching program (the state pays half, the federal government the other half). Each unit costs \$26,435.47. The first prototype has been on display in Washington for inspection of the public and government officials.

Patterned after the successful mobile Army surgical hospital unit which operated near the front lines in Korea, the FCDA hospital is designed to provide early hospitalization of seriously sick and injured as close as possible to a stricken area.

A complete hospital may be transported in a single van, weighs about 13.5 tons and consists of 450 separate packages and crates. Thirty trained and semi-trained auxiliaries can set it up in four hours. FCDA estimates the hospital would require a team of 10 physicians, 20 nurses, 125 trained auxiliaries such as nurses aides and 75 untrained personnel. Equipment includes five folding operating tables, portable x-ray unit and 200 folding canvas cots.

Maryland

STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 3

September, 1954

NUMBER 9

EDITORIAL

WHITMER B. FIROR, M.D.*

This JOURNAL, now in its third year of publication, is potentially the greatest single unifying factor in the history of our Society, a Society born only a few years after the birth



WHITMER B. FIROR

of these United States. Its ultimate effectiveness will depend largely upon you, the reader, because the comprehensive knowledge which you can gain as to the activities of your most

* Vice-Chairman, The Council of the Medical and Chirurgical Faculty.

important organization in the State of Maryland will enable you to play a more productive role in the ever-expanding responsibilities of the Faculty.

It is unfortunately true that only a small minority of the practitioners of medicine in Maryland have ever been actively engaged in the affairs of our Society. This deplorable situation can be explained only by a lack of understanding or a lack of conscience on the part of many members of the profession.

Have you ever given even ten minutes of serious thought to your Society other than when you grudgingly paid your annual dues? It may not have occurred to you that the majority of the state societies throughout the land require somewhat more financial support than is requested by the Medical and Chirurgical Faculty. It may not have occurred to you that the maintenance of high standards of medical care, of proper doctor-patient relationships, and of good public relations in general depend upon the existence and action of your professional organization. In other words, it may not have occurred to you that your State Society is the most important body in your professional life.

It is not an overstatement, therefore, to indicate that it is both a duty and a privilege of every practicing member of the profession to participate at some time in the affairs of his local and state organizations. Dues should be paid with gratitude; they should also be paid promptly, especially in consideration of the fact that physicians' defense is becoming such an important factor in this trying age when some patients are concerned with money easily gained rather than the concept of human fallibility. Meetings should be attended as regularly as possible with the conviction that these meetings should take precedence over all other professional gatherings. Your wives can do nothing more fruitful in their spare time than to become active in the Woman's Auxiliary. Finally, go to 1211 Cathedral Street to browse in the fine library, look in upon the director, and gain some knowledge of the magnitude of work being done in cramped quarters by self-sacrificing employees who have often almost broken their hearts for you and for me. The least one can do is to give them a word of appreciation of their splendid efforts.

VA PLANNING ON 110,000 DAILY PATIENT LOAD FOR FISCAL 1956

A. M. A. Washington Letter, No. 76

Veterans Administrator Harvey Higley says the agency is planning on a 110,000 daily patient load for its hospitals in fiscal 1956 (starting July 1, 1955). On the basis of a current staffing of 114,000 beds and a 90% occupancy, the new figure would mean approximately 8,000 more beds would have to be added. One estimate of hospital experts is that the cost of the 8,000 additional beds would be well in excess of \$120 million. Commented Mr. Higley in testimony before House Veterans Affairs Committee on the 110,000 figure: "We believe that isn't far off from the Bureau of the Budget's thinking, too." For the current fiscal year, the daily average patient load has been 103,000. The fiscal 1955 budget for VA providing for a daily load of 105,000 patients went to the White House this week. Under questioning on the 1955 budget, Mr. Higley said VA would be able to do a better job during the next year if it had another \$6 million. However, Reps. Pat Kearney and William Ayres raised the point that this extra money would be for non-service-connected cases and that it would, on that basis, be difficult getting Congress to go along.

COMPLETION OF 1954 TRANSACTIONS

Scientific Papers

CLUES IN CARDIOVASCULAR DIAGNOSIS AND TREATMENT¹

PAUL DUDLEY WHITE, M.D.²

DR. BENDER B. KNEISLEY, PRESIDENT: Ladies and Gentlemen, I should like to present the Chairman of our Council, and the now President of the American Heart Association, Dr. E. Cowles Andrus, who will introduce our speaker.

DR. E. COWLES ANDRUS: Dr. Kneisley, Members of the Faculty and Guests, I am very grateful for the privilege which Dr. Kneisley has conferred on me of introducing the Finney Fund lecturer who will speak on "Clues in Cardiovascular Diagnosis and Treatment." I am grateful because it gives me some opportunity to pay honor to an old friend. He has been a student all his life, a student of Cardiovascular disease and physiology in man. He has become a scholar, he has moreover imparted his scholarship and his wisdom and experience to a large group which includes eminent cardiologists all over the country and in other countries.

In the practice of his profession, he has traveled from Alaska in the North, to Argentina in the South, and literally around the world, and he has followed the biblical adage of interest in all things both great and small. He told me at dinner that the statement made about him, that he has taken electrocardiograms on humming birds is an exaggeration. He has only listened to their hearts. He has, however, studied in detail the heart of the elephant and in late years has turned his interest to aquatic animals.

He has recorded the electrocardiogram of the beluga whale, and it is not because of his own shortcomings that he failed to record it on larger whales; the apparatus didn't work. But he tells me that he has plans for next summer or the year after in the Bay of Whales, and he has just returned from a trip to Mexico where he went to represent the Cardiologists of this country, and incidentally to pull a few diplomatic strings for

access to whale fishing and studying territories in the Gulf of Southern California.

Our speaker is certainly known to you all. He is the author of the Standard Text book on Heart Disease. He is the Dean of American Cardiologists, Dr. Paul Dudley White.

Dr. Andrus, Dr. Kneisley, Dr. Compton, Ladies and Gentlemen, I appreciate very much the honor of being asked to speak this evening in honor and memory of Dr. Finney. I met Dr. Finney in Paris I think for the first time when he was in the uniform in which you see him in the portrait on the wall. I was a 1st Lieutenant at the time in the Massachusetts General Base Hospital Unit near Bordeaux, and occasionally we traveled to Paris to attend meetings and conferences; the Big Bertha was shelling Paris, I remember, on one occasion, and I then met Dr. Finney who spoke at some of the meetings and who was very kind to us. In that way I got to know him first. I saw him a few times afterwards, and it is a great privilege to be here in his honor tonight.

I think that I may be bringing, "Coals to Newcastle," talking on this subject here, but when I suggested this subject of *Clues in Cardiovascular Diagnosis and Treatment*, I was buried in Preparation of a little book on the subject, and so it was of prime interest at that moment.

Obviously, everyone has his own pet clues and in fact I have searched for some from various

¹ John M. T. Finney Fund Lecture, Annual Meeting, Medical and Chirurgical Faculty of Maryland, Baltimore, Maryland, Tuesday evening, April 27, 1954.

² Formerly Clinical Professor of Medicine, Harvard Medical School; Executive Director, National Advisory Heart Council and Consultant, Massachusetts General Hospital, Boston, Massachusetts.

friends of mine around the world, and I have added their pet clues to my own in the process of assembling this little book. Since then other things have happened and I am full of another story that I would like to tack on to this subject tonight. I shall therefore give you fewer clues (but some of the more important ones) and a bit of my latest adventures not with reference to whales, but on another much more important subject.

CLUES IN THE FAMILY HISTORY

Clues can be found, of course, in many ways; for cardiac diagnosis or for any diagnosis they come in large part through the history, the simple questioning of the patient, and observation of the patient. I believe that that is the most important way in which we can gather clues. One of the major clues is that of heredity. To gather that means obtaining a careful family history which is often neglected these days. Moreover one should go back to the grandparents and not just to the parents and brothers and sisters. I think it is most important, so far as cardiac disease of any sort is concerned, to know what the family history has been.

To illustrate the fact that one should go back of the immediate parents to the grandparents at least, is borne out by my own experience. My father's mother died of cholera in the last epidemic that came to New England, I expect from the East, in about 1860, when she was only 24 years old. My father was less than a year old then and his mother died on Bunker Hill of a disease which we never see now.

In fact I never saw a case of cholera until two years ago when I went out to Pakistan in East Bengal, and yet my own grandmother died of it. My father's father died of tuberculosis at the age of thirty odd. And so my father was brought up by his mother's parents on their farm in Randolph, Massachusetts. Meanwhile, however, his grandmother, my great grandmother, his father's mother, born in 1800, died in 1900; that is much more important I am sure so far

as I am concerned than the deaths of my grandmother from cholera and of my grandfather from tuberculosis.

Therefore one should get a fairly full history of the family. This is very important, and as I say, is often neglected. I find that most doctors with whom I speak, whose cases I am seeing, have little knowledge of the family history unless they are family doctors. Of course the family doctor has a great advantage there. He has followed his patients for years and often was the doctor of the patient's father and now may be the doctor of the patient's child as well.

CLUES IN CORONARY HEART DISEASE

Let me now take up some of the specific cardiovascular diseases and conditions more or less in the order of their importance. We come first to Coronary Heart Disease. I spoke on that subject in Baltimore a few months ago, but it is so important that I'd like to reemphasize some of the things I may have said then, and add one or two others. I shall confirm the assertion that this is the most important health problem which concerns those of us who are working in cardiovascular disease. It will also be the end of my story this evening, in the form of one of my latest adventures. The three common forms clinically of Coronary Heart Disease are 1) coronary insufficiency, shown by the symptom of Angina Pectoris, 2) the clinical condition of myocardial infarction or of coronary thrombosis with or without myocardial infarction, and 3) the various kinds of heart blocks, in particular a-v block and bundle-branch block which appear in middle or older aged people and which are certainly indicative of coronary heart disease in the majority of cases. These constitute the only conditions which should be called coronary heart disease, but I find a very loose terminology, everywhere in the world. Arteriosclerotic heart disease is a common but misleading diagnosis. If you really mean arteriosclerotic heart disease you mean coronary atherosclerotic heart disease; abbreviated, it may be called coronary heart dis-

ease. It is not aortic sclerosis or generalized arteriosclerosis which need not affect the heart at all.

Recently in the study in Naples that I will speak of later, we found great confusion in diagnosis. Some were still diagnosing myocardial sclerosis and arteriosclerotic heart disease for a wide variety of conditions, for example, for atrial fibrillation in a middle aged or older person who gave no evidence of more than an irritability of the heart.

The first clue to the diagnosis of coronary heart disease is the symptom of coronary insufficiency itself which has to be obtained usually by history. Occasionally one can observe it but I do not like to have to test my patients. You can get an adequate story by careful questioning in nearly every case. You may need ten or fifteen minutes to work the story out properly but let the patient tell his own story; then have him amplify it by asking just where the discomfort is felt, what kind of discomfort it is, and whether it is related to breathing. Often-times it is not called a pain. It may be a feeling of tightness or pressure or a "difficulty in breathing," but it isn't dyspnea. That is quite clear. Can a person point to the location with one finger? No, the person can't point to the site of the pain with one finger; the whole hand has to be used. That is very important. The palm of the hand, sometimes both hands are put across the front of the chest. Generally, of course, the symptom is central or substernal in location but it can be on either side. It is unusual for it to be only precordial instead of substernal, but the use of the palm, in the gesture of the patient, covers a wider area than that at the tip of a single finger.

This symptom was first fully described and given its name by Heberden in 1768, but I learned in Bologna a few weeks ago that it was mentioned before Heberden, without being given the name of angina pectoris. I was shown the book in which the description of angina pectoris appeared in 1747; taking great interest in this

reference I was presented with the book itself and I have brought it here. I never heard of this book before, even though I am very much interested in old medical books. Thus this book is quite new to me and this reference to angina pectoris also, and I am sure that it is new to almost everybody else. The book is printed in both Latin and Italian, it was published in 1747 in Venice, and it is entitled "The Medical Consultations of Marcello Malpighi and Giovanni Maria Lancisi." Thus these were some of the medical consultations of these two men, great leaders in Medicine in Italy in the Seventeenth and Eighteenth Centuries. Malpighi dying in 1690 and Lancisi in 1720.

The first consultations, about sixty in number are those of Malpighi, and most of them are in Latin. There began to be more Italian printed when Lancisi came along.

Before I forget it, I would add that while I was walking along the streets of Bologna a few weeks ago to see some of the sick poor at home, to make sure that we weren't missing cases who didn't enter the hospital but who were sick at home of heart disease, I passed along a street in a rather poor district of the city where there had been bombing during the war and where there was still evident a good deal of destruction, some of it repaired. As I walked along, the city doctor, the Health Department Physician who accompanied me, pointed to a doorway of a brick house we were passing. There over the door on a little marble slab was the statement that here in the seventeenth century lived Marcello Malpighi. About ten doors further down the same street on the same side was another marble slab over a doorway which said that Morgagni lived there in the eighteenth century. Thus within ten doors of each other in Bologna were the homes of those very noted Italian physicians. As you know, the statue of Galvani and his frog is also in Bologna, and Marconi lived in Bologna. It's a very historic scientific city and contains the oldest medical school still in existence. Moreover, the University of Bologna is still

going strong. Bologna followed Salerno which was the site of the first Medical School, as we define such today, established in about the year 1000; less than a couple of hundred years later came Bologna and after that Padua. It was quite thrilling to be in Bologna a month ago.

Of the first three consultations of Malpighi, the very first concerned Pope Innocent XII. The second was on the King of Poland who had some palpitation. The third was on the Queen of Poland who also had palpitation. Consultation No. 30 concerned a man who had characteristic periodic substernal pain radiating to the jaws and to the teeth. Another case suffered from periodic sternal pain radiating down the left arm, excited by stimuli of one kind and another. At autopsy his coronary arteries were unfortunately not examined. A so-called polyp was found, undoubtedly a post-mortem clot which was misconstrued for many centuries, as a type of heart disease, post-mortem clots found in the heart distracting the attention of pathologists until Kerckring set them straight. But I would like to say that at the present time some of the best study in pathology which I have seen, especially in the cardiovascular field, is being carried on in Bologna under Professor Businco who is the director of the Pathological Institute. If any of you would like a good review of cardiovascular findings, especially of aortic sclerosis during the past fifteen or twenty years, you should write to Professor Businco because he has aortograms of every case autopsied. In every case there has been prepared a diagram of the aorta, with the exact spots shown where there was atheroma or calcification or other abnormality. I don't know of any other place where such details have been collected.

I suppose that if one should go back still further to earlier works unknown to us, one might find still earlier descriptions of angina pectoris. This case report antedates Heberden by twenty-one years. Keefer and Resnick in 1928 explained the mechanism of angina pectoris very well. Prior to that important paper of

Keefer and Resnick in 1928, there was a good deal of confusion about it, but there isn't so much now. Some had thought that the pain of angina pectoris was located in the aorta, others in the heart muscle or in the nerves, or in the coronary arteries themselves. The other day, however, I acquired another old book, one by Allan Burns on the heart, published in 1809. This is ten years after the book *Syncope Anginosa* was published by Parry in 1799, in which Jenner's famous letter is recorded, first calling clear attention to the association of coronary atherosclerosis and calcification to angina pectoris and sudden death. Ten years later Allan Burns wrote this book which was published in Edinburgh in 1809. In the chapter entitled "On Disease of the Coronary Arteries and on Syncope Anginosa," he wrote "It has been long known that although the heart is always full of blood, yet it cannot appropriate to its own wants a single particle of fluid contained in its cavities. On the contrary, like every other part, it has peculiar vessels set apart for its nourishment. In health, when we excite the muscular system to more energetic action than usual, we increase the circulation in every part, so that to support this increased action, the heart and every other part has its power augmented. If, however, we call into vigorous action a limb round which we have with a moderate degree of tightness applied a ligature, we find that then the member can only support its action for a very short time, for now its supply of energy and its expenditure do not balance each other; consequently it soon, from a deficiency of nervous influence and arterial blood, fails and sinks into a state of quiescence." I have often talked to patients about this without realizing that this had already been written 150 years ago; when a tourniquet is put around the arm and there is repeated contraction of the hand, after a while the muscles of the forearm will ache. Release the tourniquet and the ache will go away. Well, this was, as quoted, clearly described by Allan Burns in 1809.

"A heart, the coronary vessels of which are

cartilaginous or ossified is in nearly a similar condition; it can, like the limb, be girthed with a moderately tight ligature, discharge its function so long as its action is moderate and equal. Increase, however, the action of the whole body, and along with the rest, that of the heart, and you will soon see exemplified the truth of what has been said, with this difference, that as there is no interruption to the action of the cardiac nerves, the heart will be able to hold out a little longer than the limb." Sometimes it doesn't however.

"If a person walks fast, ascends a steep, or mounts a pair of stairs, the circulation in the state of health is hurried, and the heart is felt beating more frequently against the ribs than usual." This applies to a healthy person. "If, however, a person with the nutrient arteries of the heart diseased in such a way as to impede the progress of the blood along them, attempt to do the same, he finds that the heart is sooner fatigued than the other parts which remain healthy." That is so characteristic. The only thing wrong with most of my patients with coronary heart disease is the state of the coronary arteries. They are perfectly healthy in every other way, with no peripheral sclerosis; often they are young and seemingly healthy, perhaps forty or forty-five years old. "When, therefore, the coronary arteries are ossified, every agent capable of increasing the action of the heart such as exercise, passion, and ardent spirits" [which have been sometimes recommended to prevent this] "must be a source of danger."

There are many cases that are said to have pseudo-angina pectoris, but there is either angina pectoris or there isn't. I think that such a term shouldn't be used. We should describe the pain and try to ascertain its cause but not label it as pseudo-angina.

The heartache of neurocirculatory asthenia is quite different. Such discomfort is an ache, not an oppression. It often lasts for hours and is associated with other symptoms. So often the symptom of angina pectoris in the average pa-

tient of mine who is forty-five or fifty years of age, is the only complaint. It usually comes on effort; it doesn't need to be very strong pain or discomfort; and there doesn't need to be very much effort to cause it. There is rarely any sense of impending death. In fact when there is a sense of impending death, usually there is predominately a nervous state whether heart disease is present or not. Many of the patients with neurocirculatory asthenia whom I see with no coronary heart disease at all, are much more afraid of imminent death than are the patients with angina pectoris, who often are not greatly worried. I would repeat that angina pectoris is likely to be the only symptom; the patients feel perfectly well between attacks and if they don't exert themselves too much they can go for months without an attack.

Another very important clue is this. Coronary insufficiency, is often very variable. It isn't in most persons an unchanging symptom over the years. A few have severe angina pectoris on effort for years, and those cases need more radical treatment if they are very much limited, but the average person that I see with angina pectoris on effort or angina pectoris decubitus, has it in the same degree only for a relatively short time, a matter of months at the most. I have never seen a patient with angina decubitus, that is angina pectoris at rest, lasting for more than a few months. That patient either dies or develops coronary thrombosis as an acute heart attack, with or without myocardial infarction, or gets better, sometimes perfectly well. And I have a good many patients who are perfectly well ten or twenty years after having been seriously ill pro tem with angina decubitus. There is no doubt in the world about that. In the old days if a person with angina pectoris got better, the general conclusion was that the diagnosis must have been wrong; therefore the doctors ruled out all the recovered cases. That is one of the chief reasons why the prognosis has been improving in the last twenty years. We now recognize the mild cases of coronary heart dis-

ease that get well, and don't fool ourselves into thinking that they are just "indigestion." Some long survivors have scars and some do not.

There may be radiation of pain, or the pain may start in an unusual place, as in the back or the wrist, or some other such unusual place. Rarely does the pain radiate lower than the midline, that is lower than the waist. I can't recall any patient who has had angina pectoris—that is coronary insufficiency pain—start below the belt. Many cases have had pain start in the shoulder or upper back, usually as a result of something abnormal in that part of the body, to which this pain is sympathetically referred. If such a person has pain start in the back or the right wrist and continues to exert himself by walking fast or uphill, the pain will gradually spread from the back or the right wrist to the substernal region. Sometimes the patient stops before that happens. Effort, then, is the key to such a symptom, sometimes with electrocardiographic corroboration.

Adam-Stokes attacks, fortunately rare, are commonly the result of coronary heart disease. Very infrequently they may result from other conditions, particularly severe rheumatic myocarditis.

Electrocardiographic evidence has, of course, great corroborative value in the diagnosis of coronary heart disease, but I think I spend more time nowadays in "undiagnosing" patients who have been "overdiagnosed" than in the reverse. I do that at least once a week in the case of electrocardiograms sent to me from a distance. Sometimes a so-called coronary patient comes in and I find merely some variation of the normal electrocardiogram. Actually we don't know the range of the normal yet. Normal variations are much too often misinterpreted as evidence of coronary heart disease.

It is always important to send for previous electrocardiograms if there is the least doubt. Once in a while I have been fooled by not doing that and so I always make a point of getting the old records because serial tracings are often

absolutely essential. Just because an electrocardiogram is normal now doesn't mean that it was normal two years ago. One can observe a complete recovery of an abnormal electrocardiogram as a physical finding in the course of years, and so one must get all the evidence there is in the past. This is essential both as regards X-ray films and as regards electrocardiograms. Don't fail to do that; now and then you will be surprised at what you see.

Sometimes there has been acute pericarditis in the past as shown by clinical evidence and by electrocardiograms that were abnormal then, but which have now become normal.

Moreover, there is normally not infrequently a slight elevation of the ST segments in the limb leads, and particularly in the V3 or V4 chest lead that is wrongly said to indicate heart disease. Also even the exercise test may be misread by the tester. One can find physiological reactions which will sometimes simulate coronary insufficiency, such as slight depression of the ST segments after exercise when there is quickening of the heart rate. The borderline of normal varies very much according to the individual who is making the interpretation. I have myself encountered several severe cardiac neurotics, aged 40 to 50 years, who have had perfectly normal hearts, but who, after an exercise test were said to have serious coronary heart disease. As in the law courts, we shouldn't condemn a person unless we are pretty sure of our evidence. At the same time even if we do have to "condemn" a patient, it is very important to emphasize the fact that our viewpoint of coronary heart disease has changed very much. We mustn't be Pollyannaish about it, but nevertheless, it is perfectly true that there are some people who have temporary changes in the coronary circulation, a touch of coronary heart disease, who are quite well later on. We can justifiably emphasize that fact to any patient we see with early coronary heart disease, even though severe, because we encounter some very severe cases who are quite well years afterward.

One of my patients to whom I occasionally refer is now 78. I saw him first 27 years ago when we were just beginning to diagnose coronary heart disease and myocardial infarction. He was a fairly average severe case, and he still shows a scar both by fluoroscope (which reveals a little cardiac aneurysm) and by electrocardiogram. He has never had any more trouble in the last 27 years. Now at 78, he plays golf with no difficulty whatsoever. Of course one can overdo exercise, but nevertheless it is very important not only not to make errors by overdiagnosing, but also to encourage those who have the disease and to get their cooperation in sensible living.

One of the clues to proper treatment of coronary heart disease is this very knowledge that a patient may spontaneously, merely with the application of common sense, get over his angina pectoris or recover well from myocardial infarction, with no special treatment at all. I saw a patient in Rome a few weeks ago who was convalescent from coronary thrombosis, an American tourist who happened to be over there, doing very well, requiring no treatment. But a very good Italian doctor with whom I saw the patient, wanted to know what drugs we would advise, and I said that I didn't think that any medicine was needed; but just a little further rest. She had had a good recovery. And he said, "don't you think a little aminophylline would be good?" I answered that I saw no harm in aminophylline and so we prescribed a little aminophylline. When we came out and walked down the street, he said "you don't use many drugs, do you?" I said "no, we don't use very many drugs in the U. S. A." He said that his conscience would hurt him unless he gave at least one medicine, because of the traditional custom of therapy in Italy.

A good deal of the credit that many medicines have wrongfully received, including even aminophylline which can be helpful, should be accorded to the natural recovery that is common in coronary heart disease, recovery that would have occurred anyway. I am absolutely sure of

that. The same is true of some of the radical surgical operations and other procedures. Hence one ought to prescribe as a rule at least six months probation before one undertakes any radical treatment. Incidentally, that is true of many conditions beside heart disease. Don't do a surgical operation for coronary heart disease or give irradiated iodine until you are quite sure that there is no change going on for a certain number of months. See what nature can do first, meanwhile using common sense measures.

Now, as to other corroborative evidence, clues, some of which are important. Sex is very important, of course. We know that the male up to the age of fifty is preponderantly the victim of coronary heart disease in contrast to the female. Therefore, if you have a patient who is a woman 35 years old, complaining of chest pain, the chances are about a hundred to one that the pain isn't angina pectoris. There is almost always some other cause for the pain. You may remember our series of two hundred cases of coronary heart disease under the age of forty. There were only seven women among the two hundred. At least two of those women were mesomorphs, which I will discuss further in a moment. Two others had hypertension. In other words there was generally a particular reason for coronary heart disease even in those women. The diagnosis of coronary heart disease in a young woman in the twenties should be viewed with considerable skepticism. One young woman aged 22 undoubtedly had pericarditis rather than coronary thrombosis as we look back now. She has been perfectly well during the 15 years since her acute illness.

The family history, of course, is of vital importance as corroborative evidence, especially if the mother as well as the father has had early coronary heart disease or cardiovascular disease of any sort.

Mesomorphy is a helpful clue. This is inherited in large part. Mesomorphy is the body build that often is described as muscular, squat, broad; it involves an individual with broad

shoulders and short wide hands. He is an early candidate in contrast to the ectomorph of lean and linear build. After the age of fifty, however, I do not think that body build counts so much.

A high serum cholesterol reading undoubtedly is of some importance but it has got to be real high. A borderline serum cholesterol is not very important. There is a wide range of the normal in the measurement of the serum cholesterol. Coronary thrombosis may occur with either low or normal as well as with high serum cholesterol. And there may be no evidence of trouble with pretty high serum cholesterol up into the lower three hundreds milligrams per cent, but when one gets up to above three hundred and fifty or more, one certainly finds a hazard then for a much greater possibility of atherosclerosis of serious degree.

When I was in Naples, there was a Professor Malmross from Lund, Sweden, who was much interested in xanthelasma and attracted my attention particularly to it. He believes quite strongly that xanthelasma is an important corroborative clue, much more so than arcus senilis.

I have spoken of the exercise and the anoxia test. I don't suppose that in more than one case in one hundred that I see, of coronary heart disease, is it necessary to think of doing any exercise test. I always hesitate a little anyway even though one can do thousands of tests without getting into trouble. Nevertheless, every time angina pectoris is produced there is a little hazard to it. It is well, if one can, to get along without such a test, and I find that that is possible in ninety-nine out of one hundred cases.

The reaction to nitrites is an important clue. Quick clearing of the symptom by nitroglycerin, in the dosage of one one-hundredth of a grain or of one two-hundredths of a grain, is diagnostic. If in the course of a few minutes there is no improvement at all, either that patient has the pain of coronary thrombosis or else the pain is due to something other than coronary insufficiency.

The presence of a cardiac aneurysm by X-ray,

of course, means an old infarct as a rule. But then one can diagnose such a case without the need of the X-ray. Hence X-ray examination is not of any great importance in the diagnosis of coronary heart disease. The same may probably be said of ballistocardiography which needs much more careful follow-up study, especially of the effect of aging, before drawing final conclusions.

CLUES IN HYPERTENSION

Now, as to clues in hypertension. I refer to important blood pressure elevation, not to blood pressures that are borderline. We see many cases that do well with hypertension of slight to moderate degree; I am not referring to that group but to the important degrees of hypertension. The importance of hypertension is shown by its effect on the heart, on the kidneys, and on the brain. Naturally if you have a patient with even slight or moderate hypertension and a cerebral vascular accident, there is probably some relationship to the hypertension therein, although the cerebral vessels and other peripheral vessels may also play a major role.

The inheritance of tissue is undoubtedly important. Many persons inherit arteries that can stand high pressure for many years. Others inherit arteries that can't stand the wear and tear, whether of hypertension or of other things. Thus there is a great variation in the effects, which can be sometimes seen in symptoms of encephalopathy or in changes in the electrocardiogram. It is very important to follow every patient with hypertension even those with not very high levels, at least annually, by electrocardiograms because of the fact that the first evidence of the effect of the strain on the heart is beginning enlargement of the heart and this is shown in the electrocardiogram as a rule long before there are any symptoms or even X-ray evidence.

Electrocardiographic Lead 1 and the chest leads over the left ventricle, especially V5, show a sinking of the T waves long before there is any inversion and before there is much left axis

deviation or much left ventricular enlargement. X-ray study of the heart is as a rule a much cruder, less sensitive test of the effect of hypertension.

The X-ray picture of the aorta in hypertension is of some importance. The aorta may show tortuosity and sclerosis, indicating an effect that may be partly hypertensive, particularly when there have been high, diastolic levels.

Patients who consistently show high diastolic levels have a serious type of hypertension which demands usually some radical treatment. About ten per cent of my patients with hypertension are serious cases. I would, therefore, for that ten per cent, substitute more radical treatment which would consist either in sympathectomy in a properly selected patient, in strict dieting, or in carefully using the new "hypotensive" drugs. I still advise Smithwick's sympathectomy in patients whose diastolic pressures are high with pulse pressures not very high and who as a rule are males between 35 and 50; their hearts may or may not already show evidence of trouble but their renal function should be reasonably good.

We now have drugs for hypertension that are fairly effective, but it is so difficult to maintain in some cases a proper level of blood pressure by drugs over years, when there are a good many years ahead, that it is sometimes well to go ahead and do the radical procedure of sympathectomy and get it over with. I have a good many patients who are quite well and have close to normal pressure with postural drop in pressure even today, ten years after Smithwick did their sympathectomy. I'm sure that I have seen many patients whose lives have been saved or prolonged by sympathectomy. The operation is a nice thing to avoid if possible, but so is the rice diet or any very severe diet low in salt. I am sure some limitation of salt is very desirable, but it is very difficult to carry on for many years on a very rigid no-salt treatment.

The use of drugs is fascinating, of course, and now with the combined use of various drugs one

can, especially in patients who are older or not suitable for these other measures, do a reasonably good job in controlling the blood pressure.

It is very important to get serial blood pressure and electrocardiographic records at least yearly in cases of hypertension. I should have mentioned that also with reference to coronary heart disease. It may be necessary to take daily electrocardiograms in suspected coronary thrombosis including the twelve leads or even more. Daily records for a week may be relatively normal before the changes appear. And so in the case of blood pressure studies, I am sure that it is very important to take records of the blood pressure or have them taken at home by the family of patients whose blood pressure may seem to be much too high in the doctor's office. I, myself, am sometimes more of a pressor agent than is ice water. In my own office, a patient enters wondering what pressure I'll find, and what I may say about it. This apprehension can send the systolic pressure up twenty, thirty, or even forty millimeters. Yet that may be the only time in the day, the only time in the week when that patient's blood pressure is so high as that. Therefore it is well to know what the basal pressure is at home as well as the pressure under stimulating circumstances, whether you use ice water or anything else such as a cigarette. The more pressures you can take, the better, avoiding of course making a neurotic of the patient, and with his full understanding. The more pressures you take day and night over a period of a few weeks, the better idea you will have of what the average pressure is in that given individual. If the pressure stays high with a diastolic reading of 120 or more millimeters at rest at home, then the patient is in for trouble. But if the diastolic pressure is 120 only in the doctor's office and gets down to reasonable levels at home for most of the rest of the day, we don't need to be so worried.

There has been too much attention paid to a few records under pressure agents and too much attention similarly paid to just the basal pres-

tures. The truth is between these two extremes. We should know both extremes and thus more or less the average between them.

CLUES IN RHEUMATIC HEART DISEASE

Just a word about rheumatic heart disease. Do we have conclusive clues of activity of rheumatism? When is rheumatism active?

Now we are getting evidence of such activity from the biopsies of the atrial appendage, and we find many patients who have seemed perfectly well so far as any infectious process is concerned, but who, while having their mitral stenosis repaired show Aschoff bodies in their atrial myocardium. What does that mean? Undoubtedly it means that there is a much greater chronicity of the active process than we have ever realized before. I think that about fifty per cent of those biopsies that have been reported here and there have shown activity even when there has been no other evidence whatsoever of activity.

Therefore, I think that we must regard more conservatively the probability of a constantly active process, very mild but which may be going ahead slowly to produce a mitral stenosis that may be quite tight at the age of thirty-five, while during the previous fifteen years there has been no evidence of any particular episode. Probably in many cases there is almost a constant very mild activity of the rheumatic process, with flareups when the patient is exposed to the hemolytic streptococcus. I suppose that the present programs that have been started, constantly to give penicillin, are the best answer. We are now tending to give penicillin all the time, even for years to these youngsters who have rheumatic heart disease and who are being followed. That may protect them.

I saw a little boy this morning in the clinic in Boston, whom I first saw a year ago when he was six years old. He is now seven. He had a grade three apical systolic murmur a year ago due apparently to active rheumatism; he was having nosebleeds then, but he didn't have any

arthritis. That murmur was the most important clue of all to the diagnosis of rheumatic fever and of rheumatic heart disease. The heart alone may afford the only clue to activity of the rheumatic process. Of course at the same time we should carefully avoid making these youngsters too heart conscious. Nevertheless it is important to follow their heart murmurs very carefully. He was put on penicillin last summer and has been on it ever since. His murmur today was only grade 1+ and he was in excellent health. His sister had scarlet fever a month ago, but he escaped. It does look as if the penicillin in his case were having a favorable influence.

We haven't any absolutely specific clue to activity of the rheumatic process but the cardiac examination is often revealing. Murmurs in many youngsters come and go, due to the temporary effect of the rheumatic process on the myocardium with dilatation of the mitral ring and not to valvular disease.

Again family inheritance and heredity come in. Family susceptibility to the reaction to the hemolytic streptococcus is another important clue.

Now as to climate, we found a lot of rheumatic heart disease in Naples recently. Southern Italy, I can assure you in early March does not have warm weather. It can be very rough. We ourselves had hail storms there this year, much rain and wind, and very little sun. By the end of March or early April, spring begins but not in early March. Naples does not have a suitable climate for anybody who is likely to have rheumatic fever or bronchitis. The houses of the poor people or even many of those of moderate circumstances are not heated. Most of the pensiones aren't heated. In fact we had planned to live in a pensione but we had to give that up because there was no heat in it. We finally went to a small hotel where there was a little heat. Many Neapolitans are crowded together in cold basement rooms, sometimes three or four or more in a room. They build a little bonfire out-

side, in front, to warm their hands. That is about all the heat they have.

The three diseases which we found most common in Naples in our recent survey included first, bronchitis, acute and chronic. When we went through the wards in the hospitals we heard many patients wheezing. In nearly every other bed there was an acute or chronic bronchitic, either male or female. I think that this is due again to the climate, and the passage of organisms back and forth, and the inability to obtain proper heat. The patients sometime wore three or four suits of underwear in bed, even in the hospital wards.

The second disease we saw commonly in Naples was nephritis, acute and chronic nephritis. I suppose that this was for the same reason.

The third was probably rheumatic fever and rheumatic heart disease. We didn't however see some of the diseases which used to be common. Even there in Naples they are uncommon now: typhoid fever and dysentery and syphilis. I saw only five cases of cardiovascular syphilis in nearly four hundred bed patients. It used to be much more common. So that, too, is now pretty well under control.

CLUES IN CONGESTIVE HEART FAILURE

Congestive heart failure is a very important condition with which most of you are quite familiar. But I would like to emphasize certain clues. In the first place there is always a factor of strain. You don't see congestive heart failure come out of a clear sky. Once in a while it is hard to tell why a patient may have had heart failure, but if you happen to see him at the time of the acute process, you may find some such causative factor as extreme paroxysmal tachycardia. You may find a heart rate of 250 or more which may be past history by the time the doctor gets there. And there may be pulmonary embolism or something of that sort that will cause in some persons, especially in older patients, heart failure without much to find be-

tween attacks. Usually, however, there is a mechanical defect or strain evident, either involving the left ventricle, such as aortic stenosis, for example, or hypertension, or a myocardial infarct of large size, or involving the right ventricle, such as mitral stenosis. I might add that the cor pulmonale was occasionally diagnosed in Naples in persons who had had chronic bronchitis for many years; I suppose that their right ventricles might be somewhat enlarged, but I doubted many of the diagnoses, since the electrocardiogram didn't show in most cases right ventricular enlargement though it did so in a few. There is no reason why they shouldn't have some cor pulmonale from their chronic bronchial disease, but high degrees of such a condition were not common.

In nearly every case of congestive heart failure the heart is enlarged. In ninety-nine per cent, I would think, of the patients I have seen who have had congestive heart failure there has been enlargement of the heart. It may not be very marked and it may come and go, since there can be a considerable difference in heart size from time to time.

The symptom of orthopnea at night is a very important clue and may give rise to insomnia. I want to emphasize the fact that insomnia in a patient who has a factor of left ventricular strain, may be an important clue to pulmonary congestion. If a patient cannot sleep, he may or may not be able at first to tell why. He may not realize that he is short of breath but he gets up and paces the room; he is restless, he wants to sit up, and he sleeps better in a chair. Always suspect the possibility of pulmonary congestion in sleepless cardiac patients. Early congestive failure may not show any edema, of course. In such a case it may be well to use therapeutic tests with digitalis, low salt intake, or even diuretics on occasion, and you may have remarkable recoveries from insomnia.

One patient whom I saw years ago was actually psychotic, unable to sleep, very very restless and about to be put into a sanatorium.

He had been given large doses of hypnotics which occasioned some of the psychosis. But when we changed and gave him digitalis and a mercurial diuretic, he needed neither hypnotics nor a sanatorium. Cough can sometimes be a clue to pulmonary congestion, but it is not a common one.

Then come the physical signs. Long before generalized edema appears, before the liver is engorged and the neck veins swell, one may find gallop rhythm, accentuation of the pulmonary second sound, and pulsus alternans, especially in a hypertensive patient. Those three signs are very important evidence of a failing left ventricle, and they demand treatment: rest, digitalis, limited salt intake, and if necessary diuretics. You may not need to give diuretics. Sometimes that is overdone nowadays. You may get along very well with rest and digitalis in most of these patients. But when you find pulsus alternans and gallop rhythm, don't wait till you get more clear evidence of congestion. Go ahead and treat to prevent congestion. Engorgement of the neck veins is late evidence of failure in most cases.

CLUES TO PULMONARY EMBOLISM

I do want to add a word about pulmonary embolism because that is often a very striking disease. It was not recognized in most medical patients when I first started practice, and really not very much until about twenty years ago when suddenly some of us became aware that pulmonary embolism in the medical wards was common, more common even than in the surgical wards postoperatively or obstetrically after delivery. It was wrongly called hypostatic pneumonia or an increase of congestive failure. Of course the clues were quite clear as we see them now. A sudden rise in temperature, not necessarily very great, an attack of dyspnea, sometimes anterior chest oppression, and particularly tachycardia, sinus tachycardia: those three things with all curves going up abruptly should make one think of pulmonary embolism,

especially in a bed patient. There may be no sign of phlebitis in the legs. Such a patient should be observed carefully for the probability of pulmonary embolism complicating heart failure or complicating anything else that keeps him in bed a long time. Sometimes there is sweating with pulmonary embolism. The process comes abruptly in contrast to the way infection starts or an increase in congestive failure develops. Then there are clues to pulmonary embolism once in a while in the electrocardiogram. About ten per cent of patients who have pulmonary embolism show evidence of the acute cor pulmonale in the electrocardiogram; these usually have massive emboli, with dilatation of the right ventricle.

CLUES TO NEUROCIRCULATORY ASTHENIA (NCA)

Now a word about neurocirculatory asthenia. Many of my patients who have shown symptoms of neurocirculatory asthenia are worried about their hearts. Others have simply cardiac neurosis, anxiety without any symptoms therefrom, because some friend has died suddenly. They are nervously worried but they aren't sighing, and they don't have a lot of palpitation and weakness in the way that the neurocirculatory asthenic patient has. Thus there is a difference between the two. The more symptoms as a rule, the less disease, unless this should be called a disease as I think it should. Neurocirculatory asthenia is after all a lack of ease but it is comforting in talking with such patients to find that they admit more and more symptomatology. In fact they admit it often before you ask them. They come in sighing and tell about their disagreeable heartache with tenderness on pressure, their palpitation and their faintness. And then there are symptoms of nervousness too. The more symptoms the less organic heart disease as a rule, although heart disease may be tacked on to NCA. You can tell him or her, and it is a little more often her than him, that careful follow-up studies have indicated that patients

with neurocirculatory asthenia survive longer than the average person. That we have proved pretty well by a long follow-up of 171 cases. They may or may not acquire other diseases but very few of them get coronary heart disease.

A CLUE TO COARCTATION OF THE AORTA

In the case of coarctation of the aorta, I'd like to mention one clue. I find that it is very helpful to listen carefully over the spine because you may find there the first and at times only good clue in the form of a moderately loud systolic or continuous murmur down the spine when you hear almost nothing abnormal in front in a young patient who has some hypertension. Therefore listen carefully along the spine and every now and then you will be able to make a clearcut diagnosis by finding that murmur.

HEART RATE IN ATRIAL FIBRILLATION

Not infrequently in cases with atrial fibrillation, the heart rate is difficult to control by digitalis or rest, unless you give massive doses. Sometimes you have to give three or four times the average dose of digitalis in order to control the heart rate. Don't hesitate to give large doses of digitalis after you have tried smaller ones. I have a number of patients now who have been taking three or four average doses every day for years in order to maintain a heart rate of 75. While some patients need only one grain or a tenth of a gram a day, others will need three or four-tenths of a gram every day of digitalis leaf or its equivalent. If you can't control the heart rate after adequate trial for a few weeks, then you should suspect one of three or four conditions, and the three most common causes for an uncontrollable heart rate in atrial fibrillation are 1) some low-grade infection like rheumatic fever, 2) infarction such as pulmonary infarction which is not an uncommon complication in some of these patients, and 3) thyrotoxicosis. Those are the three conditions which you should especially look for in such cases.

EPIDEMIOLOGICAL RESEARCH IN ITALY

Now just let me have a few minutes about this adventure that I am rather full of at the moment. In this country today and in Sweden there is, of course, much concern about the very great prevalence of coronary heart disease. Myocardial infarction has become so common that we all have friends or relatives who have it, usually men, and sometimes at a rather early age. That has been well advertised the country over, and hence many persons are very much alarmed about it. We have a right to be concerned because we don't seem to be doing much about it. The same concern exists in Sweden.

Professor Malmross of Lund, Sweden, Professor Björck of Malmö, Dr. Joe Doyle of Albany, and I joined, as a clinical team, Professor Ancel Keys from Minneapolis and his biochemical and physiological team in a study in Naples and Bologna in February and March of this year. We are just back from it. We haven't got the data all analyzed yet, but the reason we went to Naples is that we had heard that there was not much coronary heart disease in Naples. Was this true, and if so, why? Those were the two questions.

Having the entrée to the medical school in Naples through a young biochemist who had worked with him in Minnesota, Professor Ancel Keys had the run of the biochemical laboratories for his research. Dr. Keys took over with him a small team, including his wife, who is a biochemist, and a statistician, an actuary in one of the insurance companies in Minneapolis; there were also several others: a capable young biochemist from Yugoslavia, Swahn from Lund, Sweden, who had just introduced a new paper chromatographic test for the lipoproteins, alpha and beta, a young biochemist named Bronte-Stewart from South Africa, an Australian, and several young Italian doctors.

These two teams, clinical and biochemical, joined forces to make this study in Naples. Dr. Keys in early February began a study of the

serum lipids, body measurements, and electrocardiograms of typical Neapolitans, who included first, 130 heavy workers in the Ilva steel mills in Naples, second, 150 city firemen, the Vigili del Fuoco, of Naples, who have a certain amount of drill and a fair amount of exercise, but who do not work physically as hard as the steel workers, and third, about 75 clerical workers under city employ. All were much the same type of person and lived alike except for the degree of physical activity which was different for the three groups. They had much the same scale of living and ate the same type of diet which I might add is quite probably of some importance in that there is a large carbohydrate content in the Neapolitan diet, with much bread, macaroni, vegetables, and fruit, a little wine, relatively little meat or fish, some olive oil, and very little animal fat (butter, cream, eggs, and little or no pork). The blood serum was taken for cholesterol and the lipoproteins, using the same techniques that Keys and Swahn had used in Minnesota and in Sweden. Swahn came down himself from Sweden to make the tests. Electrocardiograms, physical examinations, history of diet, body build, and somatic measurements were obtained in the case of all these men.

I went to a Rotary Club Luncheon and asked for volunteers among the bankers, lawyers, doctors, and professors to be examined in the same way, and we secured quite a few volunteers. We did the same tests on them.

Then we went through the general medical wards of the hospitals and identified the patients, making notes of what diseases the patients had. We visited the different beds of the University clinics and of the Cardarelli General Hospital in Naples. We collected data on about 450 medical cases. These were average citizens, including the poor, but were not well-to-do private patients. Fearing that some might be ill at home and not seen or sent to the hospitals who might have coronary heart disease, we arranged with the city health department to go to

the homes of the poor with the city doctors; and this we did. We found that their care was reasonably good, that there were few, if any, patients sick and dying of coronary thrombosis at home who had not been in the hospitals during their illness.

One weak spot in our Naples survey was that of pathology. There are relatively few autopsies being done at the present time in Naples. Patients leave the hospitals to die at home where there are very few autopsies. Private patients have no medical hospitals to go to. That is, the well-to-do people are sick at home and die at home. The analysis of private practice in Naples is the other weak spot except that we are now getting information from several internists who will tell us how much coronary heart disease they are seeing in their practice. Professor Matteoli, who is the most experienced cardiologist of Naples and Southern Italy and one of the ablest physicians whom I have met anywhere, is writing the second edition of his book on Myocardial Infarction based on about two thousand such patients whom he himself has seen in private practice in Southern Italy. But that is not the type of patient who is in the general medical wards of the hospitals in Naples.

Hearing that in Bologna there was more coronary heart disease than in Naples, blamed locally on the rich animal fat diet which is habitual there, and having medical friends in Bologna, who have studied with us in the States, we went to Bologna to do the same thing as in Naples so far as clinical observations were concerned, but with fewer normal individuals to be tested in the same way. Professor Ancel Keys has not yet finished the analysis of his data.

I can give you very roughly for what it is worth our findings, comparing Naples with Bologna and with Boston. On my return home, we made a census of five of the hospitals in Boston, especially of the Boston City Hospital's open wards, which would be comparable to the hospital wards in Naples. Some day we should

also go to Bari in Italy, where there is a diet especially rich in olive oil.

There is a considerable difference of opinion concerning the relationship of diet to coronary heart disease. What we need now to collect are facts. Many think that diet has nothing to do with coronary heart disease. Some think that it is physical effort, including exercise that is most important in prevention. Others think, as I have thought myself, that it is total calories that count most, since we make much of our own cholesterol. Others, including Ancel Keys, think that it may be total fat, both vegetable and animal fat. Others think that it is the animal fat alone, in particular the fat found in butter, cream, eggs, and liver.

Thus, hearing that Bologna had more coronary heart disease than Naples, we went there. Of course, it has a different climate; it is north of the Apennines, a colder climate, with spring coming about a month later. We found it so when we went there. There is clearly a richer diet which is obvious right away in the restaurants; in Bologna butter is commonly eaten, pork is a common food as are also cream and eggs. In Bari, on the other hand there is a rich vegetable oil diet, olive oil. That should be investigated some time.

This same study is planned for South Africa, to examine the Bantus, the Negroes, and the whites there, and for Sweden and for different parts of the United States. At the moment, all I can say is that in 460 beds in Naples we encountered only four or five cases of coronary heart disease, all males. In Bologna in about the same number of beds there were twenty-two cases of coronary heart disease, including females.

In a letter from Lund, Sweden, yesterday, Professor Malmross said that as soon as he got home he visited the 134 medical beds at the University clinic and found twelve cases of acute myocardial infarctions. In the Boston hospitals last week, in 532 beds there were seventy-seven cases of coronary heart disease. These figures included 45 cases among 340 pa-

tients in the Boston City Hospital. Hypertension was also more common in the Boston Hospitals, there being 88 among 500 cases compared to 30 in about the same number of beds in Naples, and 35 in Bologna. Rheumatic heart disease was much more common in Naples and Bologna, there being 41 in Naples and 39 in Bologna, while there were only 26 in the Boston hospitals. There were only five cases of cardiovascular syphilis in Naples, four in Bologna and two in Boston, both at City Hospital.

One qualifying factor, certainly of some significance, though how great it is as yet too difficult to say, is that of the ages of the patients in the medical wards in Naples, Bologna, and Boston. The difference averaged a little over ten years older in Boston than in Naples and a little less than ten years older in Boston than in Bologna; there were, however, many old patients in both Naples and Bologna. The average age of the 532 medical patients in Boston was 58 years; in Naples the average was 45 years and in Bologna, 51.*

That is a brief summary of our clinical find-

* Since presenting this lecture I have been able to make a correction for age in these three cities by tabulating by sex the total number of medical ward cases in each of the three decades, 40-50, 50-60, and 60-70, and also in the same decades the number of coronary heart disease cases. They were as follows:

	40-50				50-60				60-70			
	Total ward cases		Coronary cases		Total ward cases		Coronary cases		Total ward cases		Coronary cases	
	M	F	M	F	M	F	M	F	M	F	M	F
Naples.....	44	16	1	0	61	22	71	0	44	27	3	0
Bologna.....	49	54	1	1	65	43	7	0	43	43	6	3
Boston.....	38	20	8	0	62	43	9	4	66	51	13	17
Minneapolis (Veterans)...	29	—	4	—	56	—	22	—	65	—	17	—

Total 40-70								Grand Total 40-70	
Ward Cases				Coronary Cases				Ward Cases	Coronary Cases
M		F		M		F		M + F	M + F
Naples.....		149		65		4 or 5		214	4 or 5
Bologna.....		157		140		14		297	18
Boston.....		166		114		30		280	51
Minneapolis.....		150		—		43		150	43

ings. What it may mean I don't think we can say as yet. There are many factors to consider. Race enters in, of course, but there are mixed races in both Naples and Bologna. The way of life may show itself in other respects than in diet but there is a great contrast between the well-to-do people who are members of the Rotary Club and the patients represented by the ward cases in Naples. Whether it may be worth-while for us to establish more macaroni factories in the United States and Sweden and to send our fat elsewhere it is too early to say. At any rate the fact is that we do have fairly clear evidence that something is wrong in the

United States and Sweden and we ought to do something about it. What we can do, I don't yet know. Thank you for your kind attention.

*264 Beacon Street
Boston, Massachusetts*

DR. ANDRUS: What you have just heard, this excellent and interesting discussion comes from an authority and on an authoritative note as you know. Dr. White has, as you also know, contributed much to the study and treatment of cardiovascular diseases, and may I add also that I know quite a few doctors who have slipped out of town to see him and come back and claimed that they had his blessing of the green light.

Dr. White, we are honored to have your presence, and I have the privilege of presenting to you this honorarium from the John M. T. Finney Fund.

DR. WHITE: Thank you very much.

SPECIAL FEATURES

SEMIANNUAL MEETING, OCTOBER 6, 1953

NATIONAL INSTITUTES OF HEALTH,

BETHESDA MARYLAND

PRESENTATION OF GAVEL*

Dr. Maurice C. Pincoffs, President, on behalf of the Medical and Chirurgical Faculty of the State of Maryland, presented to Dr. William S. Murphy, President of the Montgomery County Medical Society, a mahogany gavel with a gold band bearing the following inscription:

*Presented to the
Montgomery County Medical Society
In Honor of its Fiftieth Anniversary
1903-1953
by the
Medical and Chirurgical Faculty of the State of Maryland
October 6, 1953*

* * * * *

PRESENTATION OF GIFTS FOR THE AMERICAN MEDICAL EDUCATION FOUNDATION AND THE BUILDING FUND OF THE MEDICAL AND CHIRURGICAL FACULTY*

Mrs. Thomas C. Webster, President,
Woman's Auxiliary to the Baltimore City Medical Society

Dr. Pincoffs and Members of the Medical and Chirurgical Faculty of the State of Maryland:

It is with a great deal of pleasure and pride that at this time I can present to you, on behalf of the Woman's Auxiliary to the Baltimore City Medical Society, a check for five

* Presented during the Scientific Session, 2:00 p.m.

hundred dollars (\$500.00) towards the New Building Fund. Also a check for a similar amount of five hundred dollars (\$500.00) as our contribution to the American Medical Education Foundation. This money was obtained through our Faculty Ball held on April 27, 1953. It was through the generous support of many of you present that I am able to present these checks today, and I hope when you receive the notice of our Faculty Ball for 1954, that you will respond in the same manner.

Thank you so very much for giving me this opportunity.

Dr. Pincoffs accepted these gifts with appreciation, on behalf of the American Medical Education Foundation and the Medical and Chirurgical Faculty.

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DINNER DANCE

In the evening, the Montgomery County Medical Society entertained guests at a dinner dance given at the Congressional Country Club, Bethesda, Maryland.

A BRIEF HISTORY OF THE MONTGOMERY COUNTY MEDICAL SOCIETY*

J. W. BIRD, M.D.

The Montgomery County Medical Society is now well into its fiftieth year, which makes this a most appropriate time to review its history.

The first formal action toward the formation of the Society was taken on December 11, 1903, at Rockville, our county seat. Following an address on medical organization by Dr. T. A. Ashby, of Baltimore, who appeared on behalf of what the minutes refer to as the "State Society," the physicians present voted to form a permanent organization, and Dr. Roger Brooke of Sandy Spring was elected President on the fourth ballot.

The Constitution and By-Laws were approved the following April and were subscribed to by 23 physicians. Dues were fixed at \$1.00 per year, and it was decided that meetings would be held semi-annually.

Any history of an organization which has been in existence over so long a period necessarily must be based on the official minutes, which are all too

sketchy in many instances. I can say that without fear of offending anyone, because I was privileged to serve as Secretary of the Montgomery County Medical Society for 28 consecutive years—from 1920 through 1947—and there were times when it was virtually impossible for a country doctor to do full justice to that important but time-consuming job and still take care of his practice in a fast-growing community.

It was my privilege also to serve twice as President of the Society—first in 1917 and again in 1948. For the most part, our Presidents have served one-year terms, with the result that many of the County's more distinguished physicians, past and present, have filled that position.

Included in that list are two women physicians—Dr. K. A. Chapman and Dr. Naomi Lucius, who headed our Society in 1942 and 1944.

A review of the minutes of the early meetings of the Society yields a wealth of fascinating information about the medical profession and the great strides it has made in a relatively brief period. In its first years, papers were read to the Society on these important but relatively uncom-

* Paper presented at the Semiannual Meeting, National Institutes of Health, Bethesda, Maryland, Tuesday, October 6, 1953. (Fiftieth Anniversary of the Montgomery County Medical Society.)

plicated topics: "Effects of Neurasthenia on the Eyes"; "Cases of Ectopic Pregnancy"; "Treatment of Cornial Ulcers"; and "Prevention of Minor Contagious Diseases."

Forty-five and fifty years later, the minutes record papers on "The Use of Autonomic Blocking Agents in the Management of Peripheral Vascular Disease," and "Chemotherapy of Cancer with Special Relation to the Steroid Treatment of Breast Cancer." Here we have ample evidence that life is indeed becoming more complicated each year.

Our minutes also bring to light these interesting facts and dates: The first paper read to the Society, in 1904, dealt with "Medical Ethics." The speaker was Dr. George M. Kober, ex-President of the District of Columbia Society and Dean of Georgetown Medical College.

In 1905, Dr. John S. Fulton, Secretary of the State Board of Health, appeared before the Society and recommended the establishment of special sanatoria for the treatment of TB cases.

By 1906, new members were being admitted at the rate of about 8 per year.

In 1907, the Legislative Committee was instructed to take up the question of having the State inspect the County's milk supply.

In the same year came the first mention of cancer, and the Society went on record as favoring free treatment at the Pasteur Institute of indigent patients exposed to hydrophobia.

In 1908, a committee was appointed to look into the establishment of a hospital in the County to which the Society should pledge its support. Twelve years were to elapse before that need was filled by the opening of Montgomery County General Hospital at Olney.

That same year the Legislative Committee was instructed to wait upon the County Commissioners to "try to secure 10 cents for each birth reported," and it was stated that malaria was a serious problem in Rockville.

In 1909, the year in which your speaker was admitted to membership in the Society, the minutes report that the fall meeting was held at

Takoma Sanitarium where, after dinner, the members were entertained by "nurses in uniform drilling and going through various exercises." We doubtless would encounter some difficulty in arranging similar entertainment today.

Earlier in the year, Dr. Charles Farquhar had advised taking into the Society any reputable physician, regardless of school. "We may learn something from them," he added. His sound advice has been heeded through the years.

In 1910, a resolution was approved to the effect that "This Society condemns any physician who is not in hearty sympathy with the vaccine laws."

The minutes for 1910 contain the first mention of polio. A speaker stated that 8,000 cases had been officially reported in the world, 5,000 of them in the United States. He expressed his private opinion that a total of 10,000 to 15,000 cases was more likely, and added that, "of the polio cases that do not die, 75 per cent have permanent paralysis."

In 1911, it was voted to hold a special public meeting in Kensington on the growing problem of sewage disposal and to invite the County Commissioners and the Mayors and Councilmen of all County towns.

One year later the Society was told that typhoid fever had become a national disgrace. A speaker stated that "Typhoid carriers should be regulated, but full liberty allowed provided they clean their hands and finger nails."

In 1913, the members first voted in favor of medical inspection of public schools and also endorsed the establishment of TB hospitals in the County.

In 1914, the Society voted to meet quarterly. Since 1948, we have been meeting monthly except June, July, and August.

The first mention of syphilis in the minutes appears in 1915, together with the remark that "We have a race in our midst that is being decimated by the onslaught of this disease."

The first mention of either obesity or underweight appears in 1916.

The only time the Society ever failed to meet on schedule was in October of 1918, when the minute book says "No meeting on account of the prevalence of influenza." In January of the same year, only six members attended the semi-annual meeting of the Society.

As recently as 1926, the Society held a symposium on "The Importance of a Constructive Health Program in the County, Especially in Regard to School Children."

In 1928, appears the first emphasis on "heart conditions and the importance of proper diagnosis."

In 1933, the Society pledged support of pre-natal clinics in the County.

In 1934, the Society held a discussion of Birth Control clinics, no action being taken.

In 1936, a Committee was appointed to consider the formation of a Woman's Auxiliary. Nothing came of this proposal until 11 years later, when it was voted to take immediate action. The Auxiliary, which has done splendid work in the County, finally was formed in October of 1947, with 30 ladies present. In 1942, members complained about difficulty in obtaining sufficient rationed gasoline for their routine calls on patients.

In 1943, the Society was told that the new Suburban Hospital in Bethesda was assured.

A proposal by the American Red Cross to establish a Blood Bank in the County was voted down in 1947, but then was approved 18 months later.

In 1948, our Society unanimously approved a motion to the effect that "The State Faculty should grant full membership to any qualified and licensed physician without any modifications."

I might add that the Montgomery County Medical Society follows that same principle.

In 1949, much to my personal relief, the Society voted to have a part-time, paid Secretary to take minutes and perform other secretarial duties. It also approved the establishment of a cancer detection clinic.

In the following year, the Society endorsed fluoridation of the County's water supply, the first colored physician was admitted as a "full active member," and the Society heard but did not act on a suggestion that the time had come for it to have permanent office headquarters with a full-time secretary. That suggestion was made by myself.

However, the Society did install a telephone, desk and typewriter in the home of the Secretary later that year.

At the same meeting, we approved a motion calling on the State Faculty to consult us "when appointments representing medical affairs in the County were anticipated, not after they had been made."

These are just a few of the more significant and interesting items which appear in our minutes. However, there is one other matter which has required continuing attention by the Society. I refer to the question of physicians' fees.

In 1906, the Society voted that no member should examine for a life insurance company for less than \$5.00. Then, in 1908, it was officially agreed that "Members of the Society decline to issue certificates of insanity for a fee of less than \$5.00 in each case."

In 1911, the Society heard a complaint that a member physician was charging "25 cents for office calls and \$1.00 for outside calls." The Secretary was instructed to write the undercharging physician to the effect that "such charges are not in keeping with the best interests of the profession" but that "we have no regular fee bill."

In 1917, however, the Society resolved that fees for "all office visits in towns and villages will be not less than \$1.50 each, and \$2.00 per visit up to and including 5 miles from the physician's office, with an additional fee of 50 cents per mile thereafter; that night charges be not less than twice the fee for day visits; that in obstetrical cases the fee should be not less than \$15.00 in normal cases. Any violation in the charging of

proper fees shall be reported to the Society for such action as it may deem proper."

In 1933, it was reported that baby clinics just across the District of Columbia line were drawing many Maryland Babies from private practice. A committee was appointed to investigate, but the minutes contain no subsequent mention of this problem.

In 1935, just 18 years ago, the Society unanimously approved this scale of fees: \$1.00 for office visits; \$2.00 for visits up to 3 miles and 25 cents for each additional mile, and \$25.00 for obstetrical cases.

In 1943, it was reported that a post card survey showed a vote of 35 to one in favor of a minimum fee of \$3.00 for house calls. Then, in 1948, fees of \$3.00 for office visits and \$5.00 for house calls were approved.

In this connection, it is interesting to note that, in 1935, after approving the action of the State Faculty in deciding to treat indigent patients without compensation, the Montgomery County Medical Society appointed a Committee to study the care of indigent patients.

Two years later a Committee was appointed to present to the County Commissioners a plan for having the County compensate physicians for the care of such patients.

A year later in 1938, after a sampling survey had been conducted, the Society voted to ask the Commissioners to budget \$11,650 a year to reimburse physicians for the medical care of indigent patients.

The next and the last mention of that proposal to appear in the minutes was in 1941—six years after the idea first was discussed—when the Committee on Care of Indigent Patients was continued and was instructed to meet again with the Commissioners.

The Society appears never to have suffered any really serious financial problems. In fact, in 1905, after a favorable report by the Treasurer, with dues still at \$1.00 per year, the members voted themselves a dinner at the expense of the Society. In the spring of 1908, the treasurer re-

ported that all dues were paid in full but added that the treasury was about exhausted.

In 1911, there was \$64.44 in the treasury, but by 1948 there was \$2,373 on hand.

Our membership has grown steadily from the original 23 to the point where it now numbers about 250, including associate members.

As recently as 1947, a survey showed only 88 physicians practicing in the County, 66 in the metropolitan area near the District and 22 in the upper County.

Thus, the major part of the increase has come in the last few years and today, I assure you, there is no shortage of competent physicians in Montgomery County.

Part of our recent increase in membership has been due to expansion in the medical staff at Walter Reed Hospital just over the line in the District of Columbia and to the establishment of the Navy Medical Center and the National Institutes of Health in Bethesda.

The Society has 8 standing committees:

1. Program and Scientific Work
2. Judiciary
3. Public Health and Legislation
4. Public Relations
5. Medical Relations
6. Medical Defense
7. Cancer
8. Diabetic Detection

I desire to report in detail the general plan of two of the Committees.

First—The Committee of Public Health of which Dr. Robert A. Bier is Chairman. This Committee, as the name implies, is vitally interested in the health of the community and acts as the liaison between the Society and the County Health Department. This is an important committee, as it also concerns itself with the work and the scope of the Health Department in its relation to the private physician and private practice, a very volatile and active subject these days.

The Public Health Committee has studied problems and has collaborated with the Health

Department in several programs. The following are some of the recent projects worked out by the Public Health Committee and the Health Department: Examination and immunization of children by the private physician prior to entering school, examination of high school athletes by private physicians, limiting the admission to the County Clinics to those persons unable to pay for private medical services, and more recently, considering the problem of unfettered dogs attacking children.

There has been an unusually harmonious and cooperative relationship between the Medical Society and the County Health Department which has been of mutual benefit to the Society.

Second—The Public Relations Committee of which Dr. Charles I. Warfield is Chairman and who is responsible for the plan of the Montgomery County Medical Bureau established in June 1952.

1. This Bureau acts as a clearing house for all calls for the Montgomery County Medical Society and handles all the messages for its secretary.

2. It has a complete file on every physician who is a member (active, associate, affiliate, etc.), of the Medical Society, and lists their office addresses, phone numbers, specialty, hospital affiliation, hours and appointments and specialty training, etc.

3. A referral service is worked on a rotation basis. When a patient calls asking for a specialist or a general practitioner they are given three names in that category, whom they may call. These three names are then rotated to the back of the list and the system continues perpetually in this manner.

Physicians are also divided into particular localities (Silver Spring, Bethesda, Sandy Spring, etc.).

4. In July 1952, the Medical Society unanimously backed a compulsory emergency call program. Emergency calls were limited strictly to calls from fire rescue squads, or police at the scene who needed the services of a physician

before a patient could be moved to a hospital. The emergency system was divided into five areas (Silver Spring, Takoma Park, Bethesda, Rockville and Upper County). There is one man on emergency call for each of these areas each twenty-four hours. This is on an alphabetical rotation basis. The physician on emergency call in each area is notified twenty-four hours in advance, previous to his tour of duty by the medical bureau. Every physician, regardless of specialty, is included in this plan.

5. In addition, the Bureau has an alternate listing service for physicians whereby physicians may list in the phone book after their number, "if no answer call" such and such a number.

6. Every call to the bureau is recorded as to the person, nature of the call, stamped by the time clock as to time, and dispensation of the call. All these slips are then sent to Dr. Warfield for review, so that the function of the board remains at its highest standard.

7. The Medical Bureau also handles direct lines from the office of doctors. When the bureau began there were ten such lines. There are now, at the last counting, fifty-eight lines.

Our Society has, I believe, exercised a great deal of intelligent leadership in the County in matters of health and public welfare. We have endeavored to extend full cooperation whenever called on for help and advice and, in turn, we have received splendid cooperation from other County groups.

There has been a high degree of harmony in our ranks and we have been entirely free of factions. There have been few serious problems of ethics and few occasions for discipline. I believe we have the full respect of the community.

The Montgomery County Medical Society has produced two presidents of the State Faculty, a delegate to the American Medical Association, and two members to the State Board of Health. It has been my privilege to have been selected for several of those assignments. One of our members served two terms in the Maryland Senate, and another served two terms in the House of

Delegates. In addition, a member of our Society was nominated for the General Practitioner's Award of the A. M. A.

On two occasions, in 1916 and again in 1946, we had the honor of entertaining the State Faculty in our County. Some 30 physicians from Baltimore and other parts of Maryland have addressed our Society during these 50 years.

I think you can rest assured, on the basis of

our past record, that the Montgomery County Medical Society in the next 50 years will maintain the same progressive spirit and the same high degree of service that have marked this first half-century. I have every confidence that we will. It has been a real pleasure to present this brief history to you, and I hope it places our Society in a good light. Thank you very much.

Sandy Spring, Maryland

MEDICAL RESEARCH, THE PHYSICIAN, AND PUBLIC HEALTH¹

LEONARD A. SCHEELE, M.D.²

It is a real pleasure to welcome to the Clinical Center these two "ancient and honorable" associations—the Medical and Chirurgical Faculty of Maryland and the Montgomery County Medical Society. We in the Public Health Service are glad you chose the Center for this special meeting, because in doing so you claim this institution for your own. And so it is—just as it belongs to the medical community across the country. As a Federal institution, the Clinical Center exists to perform a public mission—even though the nature of the mission is highly specialized.

Because of its location, we feel—and we hope you share this feeling—that the physicians of Maryland, especially those of Montgomery County and other parts of the Greater National Capital Area, have a greater than average interest in the Center and a concern that all we do here shall come up to the expectations of scientific medicine. In the years, we in the Public Health Service intend to do all in our power to strengthen the bonds of cooperation

which have been forged with you and your professional organizations today.

I understand that immediately following this session, you will have an opportunity to inspect the Center. I have no wish to delay you, so I will take just a few minutes of your time to discuss a relationship that has brought the Clinical Center into being: that is the relationship of medical research, the physician, and public health.

Sir MacFarlane Burnet, Director of Australia's Hall Institute of Medical Research, says in a recent paper (1): "The aim of medicine in the broadest sense is to provide for every human being... the greatest fullness of health and length of life that is allowed by his genetic constitution and by the accidents of life." A natural corollary of such a statement of purpose is that the aim of medical research is to produce the knowledge wherewith medicine can help the human race achieve that high level of health and longevity.

Up until the past two or three decades, the two main areas of medical research were infectious diseases and surgery. In the past 80 years, we have attained a truly inspiring victory over the major infections. Surgical treatment has been extended beyond the highest hopes of

¹ I. Ridgeway Trimble Fund Lecture, Semiannual Meeting, Medical and Chirurgical Faculty of the State of Maryland, held at the Clinical Center (NIH) of the Public Health Service, Bethesda, Maryland, October 6, 1953, at 2:00 p.m.

² Surgeon General, Public Health Service, U. S. Department of Health, Education, and Welfare, Washington, D. C.

Lister and his contemporaries. To these signal contributions must be added improvements in human nutrition and advances in the means for compensating poor eyesight, loss of hearing, and other functional impairments.

One result of scientific and technical progress in these fields is that the physician and public health workers today have at their command the knowledge, the skills, and the armament to combat successfully a vast range of diseases and physical defects which a century ago were inaccessible to medical, surgical, or environmental control. A second result is that an even wider range of diseases and congenital defects, over which we have little or no control, now affect larger numbers of people than do the conditions for which we do have controls.

The family physician of today, for example, may see a great many patients each year with cardiovascular diseases, cancer, arthritis, diabetes, and similar chronic diseases, whereas he may go through his entire practice without seeing a single case of malaria or typhoid fever. A significant proportion of his patients will present mental disorders or physical defects of psychic origin. By appropriate immunizations, he will have protected his child patients from diphtheria, whooping cough, and tetanus; but for the infant born with retrolental fibroplasia, he can do nothing.

His colleague, the public health officer, likewise will watch the death rates from heart disease, cancer, and cerebral hemorrhage rise year by year in his community, while there will not be a single case of malaria or typhoid fever. Moreover, he will be disturbed by the increasing numbers of people from his community who are being committed to public mental institutions. His co-workers in the public welfare department, the school department, the county court, will be seeking his advice on how to handle the community's growing burden of dependency due to long-term illness, of juvenile delinquency, alcoholism, and so on.

It is the mission of medical research today—

of this Clinical Center—to give the physician and public health the answers to their dilemma—the dilemma of knowing how to deal successfully with conditions that are progressively decreasing, and not knowing how to deal with those that are progressively increasing.

The chronic diseases and congenital defects with which we must deal today call for major advances in clinical research, integrated with major advances in basic research. It is safe to say that the task is a far more formidable one than that presented to medical research by the infectious diseases 50 years ago. Once the basic principles of bacteriology and immunology had been established, and research techniques developed, it was relatively easy to achieve rapid progress, with relatively little clinical research. In chronic disease and mental illness, however, the research problems are different. To quote Burnet again: "They are complex and difficult to understand; they can be reproduced in animals only in rather crudely and distantly analogous forms—and at the present time there is virtually nothing we can do to prevent their occurrence. There is no short cut to their understanding via the laboratory bench; they can be tackled only by the direct study of human material. These are the problems that medical research must face in the future—and we may have to make considerable reorientation of our idea of medical research to do so (2)."

We feel that the Clinical Center will give us the opportunity to make such a reorientation. Here we expect to integrate laboratory studies, that are probing deeper and deeper into the living cell, with clinical studies of cancer. Here we expect to bring all the resources of biochemistry, biophysics, physiology, and related disciplines to bear upon the clinical problems of cardiovascular, metabolic, and neurological diseases. Here we expect to pursue a coordinated approach to the problems of mental disease. Here we expect to extend our understanding of virus diseases and the relationship of allergic responses to micro-organisms, as manifested in

such widely occurring conditions as rheumatic fever.

I know of no responsible investigators who believe that medical research can produce complete answers to any or all aspects of the chronic diseases within a few years time. However, the expansion of medical research in these fields since World War II has produced within a decade some results so encouraging as to give hope for major progress in some important sectors within the next 10 to 25 years. For example, the possibilities of improved diagnostic aids and chemotherapy in some types of cancer are great. Also, many authorities are confident that within a quarter of a century, medicine will have the means to master much, if not all of the untimely death and disability due to the major types of heart disease.

We expect that, with the cooperation of the medical profession and other research institutions, the Clinical Center will contribute an honorable share to these potential advances. We have more than a professional and scientific interest in making our full contribution to the solution of these problems. For the Center is here, and its combined research and medical service staffs are here in answer to the deep desire of the American people to be rid of these latter-day plagues—if such freedom can be won through medical research.

The Congressional Hearings being conducted at the present time, under the leadership of Congressman Charles A. Wolverton of New Jersey, are a reflection of the keen public interest in these health problems and their solution. It should be a matter of satisfaction to all of us that the discussions to date have revealed a solid front of cooperation among public and private groups concerned with medical research and the Nation's health.

We in the Public Health Service, as well as the private physicians and their organizations, must never lose sight of the public demand for progress against these costly and catastrophic diseases. A facility and an organization of the

Center's size and complexity is somewhat overpowering. Medical research today takes on some of the aspects of big business—whether it is conducted by a university, a foundation, an industry, or a governmental agency. The new research techniques, the new approaches to the problems which need solving, however, require facilities, equipment, supplies, and a variety of skills entirely beyond the reach of the individual scientist. In the Clinical Center, you will see research tools that need highly trained scientists simply to calibrate and utilize them. Contemporary standards for the care of patients are entirely different from those of twenty or even ten years ago.

Dr. Detlev Bronk, former President of Johns Hopkins University and the recently appointed Director of the Rockefeller Institute of Medical Research, has expressed a concern which he and many other research administrators share, lest the potential dangers of "bigness," of specialization, impair the creative force in scientific inquiry. "Scientists," he says, "whose knowledge is narrowly restricted are hampered in their research; they are unfit to form new facts in conceptual schemes . . . Modern universities all too frequently give the scientist of the future the bare bones of science, unarticulated and unclothed with the flesh of meaning—a wealth of knowledge but of a single field of science, little of related fields, and no view at all of the broad sweep of intellectual adventure through the ages (3)."

The problem for all of us in the Public Health Service, and specifically in the Clinical Center, is to surmount the threat of hampering influences. I do not share the feeling of some people that great hardship in research produces great discoveries. No, only great minds, great souls produce great discoveries. Symbolically, therefore, the Center itself challenges us to be giants—in mind and soul.

It would seem unlikely that an institution to which, eventually, almost 500 patients and their families will bring life's most poignant experi-

ences, can get out of touch with reality. And yet, it is possible in an environment more isolated than the university campus, more sharply focused on a specific way of thinking, more susceptible to narrow concepts of the aim of medical research—that this great part of the Public Health Service could lose touch with the broad aims and day-to-day problems of medicine and public health.

We are indeed fortunate to have the physicians and public health agencies of the Nation to be our friends and critics. For, while we may here pursue well-designed studies and learn the ways of team-work with our colleagues in many basic and clinical disciplines, we need always the active participation of physicians and public health officers to guide our thinking and research effort.

It is our hope that the research done here, in turn, will produce findings that the physician and the public health officer can apply in their particular spheres to the control of chronic diseases and mental illness. Dr. Vlado A. Getting in an address (4) at the Annual Session of the American Medical Association last June, pointed out that "The family physician is more than ever before in the front line of preventive medicine and health maintenance. He has an unusual opportunity to be of service to his patients and through them, to the community as a whole . . . The health department attempts to provide services to the community that cannot be provided by the family physician."

At the present time, both family physicians and public health officers are seeking more effective means to deal with the tremendous burden of chronic disease and dependency due to ill-health—on the one hand, in their patients and on the other, in the community.

For the future in chronic disease control, we can say that medical research has attained new heights in the level of scientific understanding—and will attain higher levels if the current programs are continued. While the public awaits additional answers from research institutions, physicians, hospital staffs, and public health officers must join in an exploration of new roads to cooperative services. In doing so, these front-line workers can undoubtedly contribute to the medical research effort by careful trial of new techniques, by the follow-up of research patients, and by reporting all they can learn about the early stages of these diseases. The family physician, the local hospital, and often the industrial physician and the health officer, are far more likely to see early cases than are the specialists and the research institutions.

Here at the Center we hope to have many private physicians, hospitals, and public health departments participating in our research programs. I am sure that this type of cooperation will ultimately enable American medicine to achieve its broad aims of "fullness of health and length of life" for every person—even in the face of the rising tide of chronic disease and mental illness.

*Department of Health, Education, and Welfare
Public Health Service
Washington 25, D. C.*

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RECEPTION ROOM MAGAZINE

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Reports

COMMITTEE FOR THE STUDY OF PELVIC CANCER

BEVERLEY C. COMPTON, M.D.*

The Committee for the Study of Pelvic Cancer meets in the Medical and Chirurgical Faculty Building on the third Thursday of each month, September-June, from 5-6 P.M.

Abstracts of Case Discussions:

Case I. M. P. White. Age: 30 years. Married. Para 1. Beginning in January 1952, menstrual periods completely irregular—intermittent bleeding varying from faint pink spotting to a gush of bright red blood. Also at this time abdominal pain extending from mid-line to lower right quadrant. Consulted doctor A in early February—oral medication prescribed and patient told that symptoms were probably due to the fact that she had to be on her feet constantly while at work. Consulted doctor A every week or two over a period of several weeks. Beginning in March, continuous, profuse yellowish vaginal discharge of foul odor. Consulted doctor B in late April—was examined and told that she had “trouble with womb.” Rx. Douches. In June, three episodes of profuse bleeding. Doctor B referred the patient to the hospital clinic about June 15th. Patient hospitalized June 25th.

Diagnosis: Squamous cell carcinoma, cervix, I. C. III.

Treatment: Radium and deep x ray therapy.

Chairman: For the benefit of those who are attending these meetings for the first time, I would like to say that the purpose of this Committee in reviewing cases of pelvic cancer is to attempt to reduce delay periods in diagnosis and treatment. The objective is educational and not critical. We hope that the discussion of cases may be of benefit to all physicians. In reviewing cases we classify them as patient delay, physician delay or institutional delay. We consider a time lapse of more than one month as delay.

In this particular case we cannot say definitely as to patient delay because we do not know the exact dates of the onset of symptoms or of the first medical consultation. There appears to have been treatment delay on the part of both physicians. Is there any comment on this case?

Visiting surgeon: This case was treated at our hospital. The history is substantially as given in the abstract. Our records indicate consultation with doctor A but note that a pelvic examination was not made by this physician. Doctor B was consulted on the 3rd, 6th and 10th of May and a pelvic examination was made on the 10th with the diagnosis of cervicitis and salpingitis. He referred the patient to our clinic about the 19th of June when she was bleeding profusely. She was admitted to the hospital on June 25th and diagnosed as Stage 3 or possibly 4.

Chairman: The delay in this case between February and June might mean the difference between curable and incurable cancer.

Visiting surgeon: We considered it advisable in this case to treat the patient with x-ray first and then re-admit her to the hospital for examination and re-evaluation before radium. We did give the radium but at that time there appeared to be a mass extending into the rectum.

Dr. Scheffey and Dr. McKelvey have advocated x-ray routinely before radium. I would like to ask for an opinion on that.

Chairman: In the case of a big, sloughing ulcerative lesion with infection it is often wise to try to disseminate the infection and shrink the mass with x-ray.

There was considerable discussion of this matter.

Visiting surgeon: Incidentally, the Papanicolaou smear on this patient following irradiation, showed atrophic cells.

There was discussion of the value of Papanicolaou smears following irradiation. The consensus was that a positive smear might indicate that the tumor is resistant, but many false negatives are obtained, indicating only that the local lesion is atrophic. The studies made by Dr. Meigs and Mrs. Graham were cited. It was emphasized that the work of Mrs. Graham has dealt particularly with the radiation reaction of normal cells—i.e., a certain reaction in normal cells will indicate whether or not a tumor will be radio-sensitive. The figures from this study were thought to be impressive.

* Secretary. Under the auspices of the Medical and Chirurgical Faculty and the Maryland Division of the American Cancer Society.

Case II. M. B. White. Age: 33 years. Married. Para 1. Right ovarian cyst removed in 1951. In April, 1953, considerable abdominal discomfort and yellow vaginal discharge. No menstrual irregularity. Consulted doctor A in early May—pelvic examination made—patient told that she had an ulcer and the lesion was treated with local applications. She remained under the care of doctor A until referred to the hospital clinic in early July. Following examination the impression was that the lesion was benign, possibly caused by the application of a strong chemical. Rx. Aureomycin suppositories and astringent vaginal douche. Patient returned to the clinic two or three times—no improvement—hospitalized for biopsy September 3rd. (Serology found to be positive at this time.) At the time of biopsy the tentative diagnosis was tertiary syphilitic ulcer of the vaginal vault; chronic cervicitis. The pathological report: Papilloma of the vagina, beginning squamous cell carcinomatous change in vaginal wall; chronic cervicitis. Patient re-admitted on September 21st for diagnostic D. & C. and multiple punch biopsies of the cervix and ulcer of vaginal vault. Referred to second hospital for treatment September 29th.

Diagnosis: Primary carcinoma of the vagina.

Treatment: Radium and deep x-ray therapy.

Committee member: Very often we do not know why there is delay on the part of the physician or institution. In this case, I saw the patient when she first came to the hospital clinic and failed to realize that we were dealing with a carcinoma of the vaginal vault. The gross lesion appeared to be a superficial ulcer with considerable secondary infection. After clearing up the infection, the patient improved clinically but the lesion itself did not show improvement. I did not see the patient following her first visit to the clinic because I was away. I feel the house staff should be congratulated that they realized the lesion should be biopsied and sent the patient in to the hospital. The biopsy finding is as given on the discussion sheet. All of us were surprised to find that we were dealing with a primary carcinoma of the vagina. The lesion appeared to be confined to the right lateral vaginal vault. The biopsies of the cervix taken at the time the patient was re-admitted for D. & C. were negative.

Visiting surgeon: The biopsy taken at the time this patient was admitted to the second hospital for treatment did not show carcinoma, but only papilloma. It was thought, however, that there was no question of the diagnosis as it was proved twice at the first hospital. The lesion was early but a definite malignant process.

Chairman: Primary carcinoma of the vagina is relatively rare and it is fortunate that this one was

detected while still an early lesion. We have no further information from doctor A but there appears to have been some delay in referring the patient to the hospital. There was also some hospital delay in establishing the diagnosis.

Case III. R. D. White. Age: 40 years. Married. Para 3. Patient first seen in hospital gyn. clinic in February of 1950 because of diabetic vulvitis. Biopsy of the cervix at this time was very suspicious of malignancy. In March, biopsy said to show "question of intraepithelial carcinoma of the cervix." In May, two biopsies were reported as chronic cervicitis. Patient requested to return in three months but failed to keep the appointment. In September, 1951, patient had elective Caesarian because of diabetes—a low cervical section was done and the right uterine artery was lacerated and thereafter a sub-total abdominal hysterectomy was performed. (Ob. history notes cervix as "markedly eroded—consider biopsy," but this apparently was not done.) In 1952, patient was followed in diabetic clinic. She did not return to gyn. clinic until July 1953, at which time she was complaining of urinary tract symptoms. July 9th, biopsy showed "probable epidermoid carcinoma, cervix." Examination revealed a mass in the left paracervical region which was thought to be an enlarged pelvic lymph node. Patient hospitalized for biopsy of this mass and conization.

Diagnosis: Epidermoid carcinoma, cervical stump, I. C. III.

Treatment: Deep x-ray therapy. Radium.

Chairman: This is one of our cases and I have reviewed the slides. My feeling is that the sections showed definite intraepithelial carcinoma in March of 1950; normal cervix in May 1950; invasive cancer in July 1953.

Committee member: This has been an extremely interesting case. It is one of the rather rare cases where there is no gross lesion on the cervix, but microscopically invasive cancer. This cervix looked normal even at the time the mass in the left paracervical region showed definite invasive cancer. I feel that there was certainly delay on the part of the hospital and that probably even in 1950 the patient was followed too long without conization. Lack of cooperation on the part of the patient was a factor but not an excuse. She was subsequently followed in other clinics in the hospital but apparently not referred back to gynecology for further investigation.

Chairman: I do not feel that there can be criticism of the obstetrical department in doing a sub-total hysterectomy as the emergency procedure at the time of the Caesarian section.

Visiting surgeon: There is no criticism of the surgery but with the patient's history of questionable

intraepithelial carcinoma, it seems that a later biopsy of the cervix was indicated.

Committee member: It undoubtedly should have been done but for some reason was overlooked.

Committee member: This case presented many complications but in the final analysis it appears to be a case of intraepithelial carcinoma which "got away." I would like to point out that in 1950 cases of possible intraepithelial carcinoma were not followed as they are today. At the present time in this hospital careful records and follow-ups are maintained on all of these patients.

Case IV. F. J. White. Age: 29 years. Married. Para 7. Menses said to be normal to June 1953. Normal period June 1st. No period in July and August—consulted doctor A—was examined and found to be pregnant. Beginning in the third month of pregnancy and continuing, a malodorous vaginal discharge with occasional slight bleeding. Patient was told by doctor A that she had a "torn place." In October or November she received penicillin injections for the discharge. December 27th, an episode of moderate vaginal bleeding—consulted doctor A who advised bed rest. Bleeding recurred more profusely on December 31st and patient was admitted to the hospital. Examination under anaesthesia on January 4th, revealed a "growth on the mouth of the womb." Patient was transferred to second hospital for therapy. Biopsy showed epidermoid carcinoma. Caesarian section and removal of tubes, January 11th, 1954.

Diagnosis: Epidermoid carcinoma, cervix, I. C. II, late.

Treatment: Radium and deep x-ray therapy.

Chairman: We regret that doctor A is unable to attend the meeting today and we have no further information to add to the history as given in the abstract. This case is similar to several others seen during the Committee's study where there was a rather far-advanced malignancy which was not detected until late in the pregnancy. Physicians too often have in mind only the possibility of abortion and thus the actual cause of irregular bleeding is not determined. In some cases a pelvic examination has not been done.

Visiting surgeon: In this case the attending physician made repeated pelvic examinations throughout the pregnancy but did not biopsy the cervix.

Committee member: By the time the patient was hospitalized for treatment she had a very bad looking cervix—almost a stage 3. Before a definite decision had been reached as to how best to treat this case, the patient's membranes ruptured spontaneously and therefore the Caesarian was done prior to radium

treatment. The removal of the tubes was advised at the time of operation in order to eliminate the possibility of salpingitis as a complication.

There was discussion of the rather wide-spread, but erroneous, impression that biopsying a cervix will upset a pregnancy. A study made at the Hopkins Hospital was quoted. In this series of 260 cases where the cervix was biopsied during pregnancy there was only one abortion and one serious hemorrhage thought to be attributable to biopsy.

Case V. I. H. White. Age: 46 years. Married. Para 1. Menses normal to September, 1952. Following period in September, moderate vaginal discharge which continued for two weeks. Regular periods October–March, but slight spotting or moderate bleeding almost daily between periods. March, 1953, moderately profuse bleeding for one week—consulted doctor A—was not examined because of the bleeding—given an injection and oral medication to check the bleeding and asked to return when bleeding stopped. The bleeding ceased entirely for two weeks in April. The patient thought her symptoms were due to the menopause and did not return to the doctor. May and June, bleeding almost daily. July 5th, "hemorrhage." The patient was taken to the hospital and doctor A called in consultation. Following a diagnostic D. & C. and biopsy the patient was sent to second hospital for treatment.

Diagnosis: Epidermoid carcinoma, cervix, transitional cell type, I. C. III.

Treatment: Deep x-ray therapy. Radium.

Chairman: This case is similar to many which have been presented at these meetings. The patient is not examined because of bleeding, given medication to check the bleeding, and requested to return for examination when the bleeding stops. For varying reasons the patient does not return until after considerable time has elapsed and the disease is rather far-advanced before the diagnosis is made. Had this patient been examined when she first sought medical advice she might have come to treatment much earlier.

Committee member: We have discussed this matter many times but apparently we cannot emphasize too strongly that bleeding is not a contra-indication to examination. Examination at this time may often be a help in establishing a diagnosis.

Case VI. L. C. White. Age: 38 years. Married. Para 2. Patient came to hospital clinic December 9, 1953, because of urinary difficulty—frequency, urgency and pain. Periods said to be normal, no irregular bleeding. Routine Papanicolaou smear reported as class 5. Biopsy done on January 5th re-

vealed intraepithelial carcinoma of the cervix. The patient was hospitalized January 10th for D. & C. and sharp conization. Pathological report: Intraepithelial carcinoma, cervix, with one small area of invasion of submucosa. On January 19th, the patient had a panhysterectomy. The pathology showed intraepithelial carcinoma of the cervix.

This case was presented as of interest because of the detection of the early carcinoma in the absence of definite symptoms.

Statistics

Cases to June 1, 1954.....	667
Classification:	
Patient Delay.....	303
Physician Delay.....	56
Patient and Physician Delay.....	36
Institutional Delay.....	20
Physician and Institutional Delay.....	3
Patient and Institutional Delay.....	13
Patient, Physician and Institutional Delay.....	2
No Delay.....	214
Asymptomatic Detected Cases.....	20

COMMITTEE ON PUBLIC MEDICAL EDUCATION

H. HANFORD HOPKINS, M.D.*

In the Fall of 1953, Dr. Amos Koontz, then Chairman of the Committee on Public Medical Education of the Baltimore City Medical Society, conceived the idea of making available to the Public, information on Medical subjects of popular appeal through the medium of a group of speakers who might volunteer from among the members of the Baltimore City Medical Society.

With the help of the A. M. A. and other agencies, a list of topics was prepared, and on November 30, 1953, mailed to the lay organizations of Baltimore and its environs for which addresses were available.

* Chairman, Committee on Public Medical Education.

At the same time a panel of volunteer speakers on the various subjects was compiled.

Since the beginning of the program, requests for forty-five talks have been answered, and the engagements fulfilled by thirty-four different doctors. The medical subjects selected by the Public have been quite varied except that recently as might be expected there has been a rash of requests for talks on cancer of the lung.

We have no means of knowing whether or not all expositions have been well received, but feel very much encouraged in our effort by the complete absence of adverse criticism, and very naturally by the following letter, which among other letters of similar nature, I think will be of some interest to all Maryland doctors who read it:

BALTIMORE FEDERATION OF LABOR

Affiliated with the American Federation of Labor
1131 Harford Avenue
Baltimore 2, Maryland
Phone Peabody 2-6021

July 22, 1954

"Dr. H. Hanford Hopkins, Chairman
Committee on Public Medical Education
Baltimore City Medical Society
1211 Cathedral Street
Baltimore 1, Maryland

My dear Dr. Hopkins:

Last evening, Dr. Carleton C. Douglass addressed our organization on "Cancer of the Lung," and I might add that the delegates to our meeting were greatly impressed with Dr. Douglass's remarks and the manner in which he delivered his very informative address.

On behalf of the officers and members of this Federation, I want to take this opportunity to thank you for your part in arranging for our speaker.

If we can ever be of any assistance to you and your organization, please do not hesitate to call upon us.

Sincerely yours,
(Signed) Francis S. Filbey
President

July 24, 1954

SENATE VOTES MORE VA DENTAL CARE FUNDS

The AMA Washington Letter, No. 72

Indorsing action of its Appropriations Committee, the Senate has approved \$10 million more than the House allowed for Veterans Administration private fee payments to dentists. The committee explained that it took the action because the bill as passed by the House sharply reduced dental care funds, while at the same time it lifted restrictions on dental care. The committee decided on increasing the funds rather than restoring the restrictions.

ARTICLES OF INTEREST

ON LICENSING LABORATORY WORKERS*

AMOS R. KOONTZ, M.D.

There is a movement on foot for setting up a State Board in Maryland for licensing medical laboratory workers. Indeed a bill for the enactment of the proposed law is being prepared. The advocates of the law profess the belief that such a law would improve the quality of medical laboratory work in the State. I am not convinced of this and do not see the necessity for the establishment of such a board.

I believe that all medical laboratory workers should work under the supervision of physicians. This practice has worked out very well in the past and I believe should be continued. If medical laboratory workers were licensed, they would be free to carry on their laboratory work without medical guidance, which is undesirable.

As a matter of fact, there is now very little need for licensing physicians, except those who come from

foreign countries. Through the efforts of the American Medical Association all of the old class B and C medical schools have been eliminated. There are now no poor medical schools in the United States. It is the general advance in medical education which has improved medical practice and medical care in this country and not the system of licensing physicians.

The same principles hold with regard to laboratory workers. As medicine improves, they will improve, and if they are required to work under the direction of physicians, there will be no necessity for licensing them.

Should laboratory workers be licensed, they would be withdrawn more or less from medical supervision, and would be enabled to form a guild of their own. This is not desirable. Nurses are licensed and have their own associations, which is desirable in one way but undesirable in others. While the work of nurses has an inseparable relationship to the medical profession, nursing education is not controlled by the medical profession. Nurses training has now become so complicated with lectures and laboratory work that there is very little time for them to spend on patients. Most physicians consider this very undesirable and yet it is beyond their control. We do not want the medical laboratory workers to get into the same situation.

* As a result of the polling of the Component Medical Societies, the Council of the Medical and Chirurgical Faculty at its meeting on June 1, 1954, adopted the following motion: *That this Council record itself as opposed to the proposal of Dr. C. A. Perry for a law providing for State Licensure of Laboratory Workers.*

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The following candidates from Maryland were certified by the American Board of Obstetrics and Gynecology on May 17, 1954:

Fitzpatrick, Vincent D., Jr., 1120 St. Paul Street, Baltimore, Maryland
Haight, John S., 3303 Perry Street, Mt. Rainier, Maryland
McCune, Wallace H., 8208 Fenton Street, Silver Spring, Maryland
Moody, Louis H., Jr., 918 Ellsworth Drive, Silver Spring, Maryland
Reist, Vorris M., U. S. Naval Hospital, Bainbridge, Maryland
Russell, Thomas E., Jr., 3901 North Charles Street, Baltimore, Maryland
Scher, Ernest, 1701 Eutaw Place, Baltimore, Maryland
Warren, John F., 6805 Baltimore Blvd., College Park, Maryland

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

Lt. Col. J. Norman Reeves will report for overseas duty after spending a few days furlough at his home in Westernport, Maryland.

Dr. Wylie Faw has been elected to The Maryland State Board of Medical Examiners.

Dr. Hilda Jane Walters, Frostburg, Maryland, was injured in a highway collision.

Dr. Benedict Skitarelic, Director of Laboratories, at the Memorial Hospital, in Cumberland, has promoted a Sports Car Race.

Dr. Raymond W. Reeves of Westernport, the twin brother of Lt. Col. J. N. Reeves, will report for active duty with the Air Force.

Dr. Ralph Ballin addressed the Maryland State Nurses Association, District 1, on May 26, 1954. Dr. Ballin spoke on "Psychosomatic Aspects of Heart Disease."

Dr. Ralph Roth, of Cumberland, Maryland, plans to study at Jefferson Hospital, Philadelphia, Pennsylvania.

Dr. Leonard S. Cooper, of Cumberland, plans to leave local medical duties in order to specialize in surgery at Sayre, Pennsylvania.

Dr. Cooper expects to return to Cumberland to engage in surgery.

Dr. Harold W. Eliason has been appointed Physician to the Cumberland City Health Department, effective July 1, 1954.

Dr. Eliason has lived in Cumberland since 1928. He graduated from the University of Maryland in 1927, after attending St. Johns College, Annapolis and the West Virginia University. Dr. Eliason's practice is limited in Pediatrics and he holds the position of Chief of Pediatrics at Cumberland and Allegany County's Memorial Hospital. He is a native of Rowlesburg, West Virginia.

Dr. W. E. Gattens, of Frostburg, Maryland, was elected president of the medical staff of Miners

Hospital, in Frostburg, Maryland, at a recent dinner meeting.

Other officers named included Dr. H. C. Diehl, vice president; Dr. Martin Rothstein, secretary, and Dr. Hilda J. Walters, Dr. W. O. McLane and Dr. Harry Teter, executive committee.

Dr. Gattens succeeds Dr. Walters as president.

Dr. W. Royce Hodges explains use of "Rockette" for babies.

BALTIMORE CITY MEDICAL SOCIETY SECTION OF GENERAL PRACTICE

KENNETH KRULEVITZ, M.D., *Secretary*

The newly formed Section of General Practice met at the Medical Chirurgical Building, June 10, 1954. This was the first official meeting of the organization. A paper by Dr. Paul Carliner, Chairman of the Baltimore City Emergency Medical Call Program, was read. Following this paper members of the Section held a discussion of the problems involved in handling the large number of emergency calls. A committee of the general practitioners of the Section was formed to participate in further studies with Dr. Carliner's committee. Members of this committee are: Dr. Charles Kerr, Dr. Louis Klimes, Dr. Samuel Rubin, and Dr. Marion Freedman.

The following committees of the General Practice Section are to be formed: Programs Committee, Constitution Committee, Membership Committee, and Public Relations Committee.

The Section intends to meet on the third Thursday of each month at 9:30 p.m. at the Medical Chirurgical Building. This day and time were selected as being most suitable after a questionnaire was sent to the general practitioners of Baltimore City.

The first meeting will be held Thursday, October 21, 1954, at 9:30 p.m. Dr. Joseph Blum, Chairman of the Program Committee, is formulating plans for the first meeting.

Dr. Charles Kerr was appointed Section Representative for the Committee on Scientific Arrangements.

Officers for the 1954-55 term were elected as follows: Dr. Louis Maser, President; Dr. Walter Anderson, Vice President; Dr. Kenneth Krulevitz, Secretary; Dr. Marion Freedman, Treasurer.

It is hoped that all general practitioners will become interested and active members of this Section.

SECTION ON INTERNAL MEDICINE

INTERNAL MEDICINE AND BLUE SHIELD:

I. Fact Finding Committee's Report*

CONRAD ACTON, M.D., *Chairman*

This Committee was instructed to seek out *facts* concerning medical, as distinguished from surgical, benefits under various Blue Shield, or prepayment medical benefit insurance plans, and report to the Section at this date. The Report to be a basis for any action the Section might decide to take. Relevant facts were sought by:

- (a) Discussion with other physicians.
- (b) Review of pertinent literature.
- (c) Analysis of "Voluntary prepayment Medical Plans"—1953, from A.M.A.
- (d) Conference with Maryland Medical Plan, Inc., representatives:

Mr. R. H. Dabney and Dr. Walter Graham. The following facts as found are herewith submitted.

1. There is a generally recognized—within the medical profession—inequity between surgical and medical benefits under Blue Shield Plans. Manifestations of concern range from "Medical Economics" facile, sort of soap-opera dramatics editorial on page 97 of the July 1953 handout, to the deliberations of the Board of Regents of the American College of Physicians. Their sober and restrained opinion is reported on page 415, (3), in the August 1953 "Annals of Internal Medicine." On motion of Walter Martin, then A.M.A. President-elect, it was agreed that "This ought to go to the Section on Internal Medicine of the A.M.A., to be considered by them and then referred to the proper body of the A.M.A., as to what shall be done. . . ."

2. There are two major barriers to effective understanding between Physicians and Insurance Men.

* Presented to Section on Internal Medicine, Baltimore City Medical Society, 29 September 1953.

(a) Actuarial terminology, concepts, and philosophy underlie Blue Shield Plans, not medical. These plans are "medical" in name only. For instance, "medical" benefits are paid to surgeons, or other physicians, when they do not operate on a patient.

(b) The concept of insurability. Not everything is insurable. Insurability requires that the item insured against shall be of uncertain or unique occurrence—that the item's occurrence shall be predictable by the laws of chance and probability, if not already on established tables of past experience, like appendicitis, or fractured femurs, in terms of frequency per unit group per time term. On the other hand, an event that is certain to occur is not a risk, and is not insurable. All insurance carriers seem to believe that if a "medical examination," or "diagnosis" however phrased, were included in the various Tables of Benefits, or payments, such a Benefit would be universally indulged in, as in the British experience. The benefit then would have to be added to the subscription rate from the beginning as a "cost" and make the rates unconscionably high.

3. "Benefit" payments of Blue Shield Plans can be compared on a nationwide scale in the booklet "Voluntary Prepayment Medical Benefit Plans—1953." It is prepared and distributed gratis by the Council on Medical Service, A.M.A. Sixty-five of those listed were analyzed. The following facts stand out:

(a) All Plans are not "accepted" as approved by the A.M.A. but are listed. Non-acceptance is for non-conformity to one or more A.M.A. policies. The Maryland Medical Plan is not accepted because participating physicians are paid more than non-participating, 25%.

(b) Eleven (11) plans have *NO* (not any) medical benefits at all.

(c) Twenty-three (23) pay non-surgical benefits *only after* the first two (2) to five (5) days of hospitalization.

(c) *Maximum* (NON-SURGICAL) BENEFIT PER DAY, usually first day, other days less.

11 pay NOTHING	
5 pay \$2.00	1 pays \$6.00
35 pay 3.00	7 pay 10.00
11 pay 4.00	1 pays 12.50
23 pay 5.00	1 pays 15.00 (MARYLAND)
	1 pays 25.00 (NEW JERSEY)

(d) *Maximum* (NON-SURGICAL) BENEFIT PER HOSPITALIZATION varies naturally with the rate after the first day, and allowed benefit period.

11 pay NO non-surgical benefits.

2 permit a \$50.00 *Total* (Kentucky, W. Virginia)

1 allows \$603.00 (California)

MARYLAND permits a total possible of \$109.00

16 range \$50.00 to \$95.00

9 range 100.00 to 140.00

7 range 150.00 to 180.00

5 range 216.00 to 220.00

4 range 350.00 to 482.00

2 range 507.52 to 603.00

4. Benefits are also allowed for CONSULTATIONS. Of 65 evaluated:

(a) Forty-three (66%) have NO Consultation benefits at all.

(b) Twenty-two (33%) allow \$10.00 each for total of two consultations per consultant, very uniformly. Occasionally a second consultant may be authorized in some.

(c) No Blue Shield Plan distinguishes between consultants or consultations in any way whatever. A consultation is a consultation. No time limits are set: five minutes equals five days. Investigation is the same as therapy. Specialists rate equally whether fully qualified, semi-detached, or grass-roots calibre.

5. Figures from the MARYLAND MEDICAL SERVICE, Inc., show the following resume of payments of a medical and surgical nature: in 1953: (Final figures compiled in 1954.)

	<i>% Claims</i>	<i>\$ Paid</i>	<i>Average</i>
Medical (Non-surgical)	3,003	\$154,611.00	\$51.00
Medical Consultation	763	7,620.50	10.00
Surgical	7,279	473,958.00	85.00
Surgical Consultation	277	2,761.50	10.00

6. The Maryland Medical Plan compares favorably with other plans as outlined in the comparative tables.

7. No Blue Shield Plan distinguishes between TYPES of consultation.

8. No Blue Shield Plan recognizes "non-surgical" *specialties* in any Table of Benefits.

BALTIMORE COUNTY MEDICAL ASSOCIATION

SAMUEL P. SCALIA, M.D.

Journal Representative

The June meeting of the Baltimore County Medical Association was a joint meeting with the Woman's Auxiliary. It was held at the Ames Fellowship Hall in Pikesville.

As usual, the June meeting is devoted by the Auxiliary to the granting of a nursing scholarship. This year, the women were able to grant two scholarships to two County high school graduates. One girl is to go to St. Agnes Hospital and the other to the Church Home and Hospital.

This nursing scholarship project has been a very worthy one for Baltimore County. The Auxiliary has gained national recognition because of its endeavors. The three previous scholarship winners were guests at the meeting. One girl has just graduated from the University Hospital, one is a senior at Woman's Hospital, and the third one is a second year student at Johns Hopkins Hospital. The Woman's Auxiliary is to be commended for a job well done.

A new idea was introduced by Dr. Warthen concerning chest x-ray reports. Formerly all chest x-rays were routinely read for pulmonary tuberculosis and nothing else; from now on, any other significant chest pathology will also be described in the reports. The patient will be notified that the x-ray showed some pathology and that he should contact his family physician. The doctor will receive a full report of the findings and he takes over from there.

Dr. Isadore Tuerk has had to give up his position as Director of the Alcohol Study Clinic in Baltimore County. Dr. Charles Ward is succeeding him. Dr. Ward discussed the functions of the clinic and its value in the county. He made a request for more referrals from the county physicians. The clinic is very well staffed and running quite smoothly. He feels that they can probably handle more patients than there are at present.

Dr. Robert Thomas was introduced to the membership. Dr. Thomas is succeeding Dr. Paul Lemkau as Director of the division of Mental Health in the State Health Department. Dr.

Thomas outlined the Program of Mental Health in the State and especially in Baltimore County. He stressed the importance of the Mental Health clinic as regards treatment and prevention. A new aspect of the clinic was brought out in that these clinics are now being used for training of psychiatrists, clinical psychologists and psychiatric social workers. The Mental Health clinics certainly deserve full support.

Crabs to delight the palate of the most exacting connoisseur of that famous Maryland dish; Crabs to tickle the taste buds of Baltimore County physicians and cold beer to bathe the warm temperaments of medical men on a hot day: This was the order of the day when the Baltimore County Medical Association held its annual crab feast at Duffy's Restaurant on Wednesday, July 28, 1954.

There were steamed crabs and crab cakes, crab imperial and crab soup, and of course cold beer. A good crowd turned out and everyone had an enjoyable afternoon.

The scientific part of the meeting concerned itself with the digestive processes and their relationship to crabs and beer. It was decided that more research is needed before reaching any definite conclusions. Therefore, it was moved to have another crab feast next year as a form of applied research.

The response to a request for articles for a Baltimore County issue of the State Medical Journal has really been overwhelming. As a result, there will probably be two issues of the JOURNAL devoted to our County. We are all anxiously looking forward to seeing our scientific endeavors in print.

The JOURNAL Representative, Samuel P. Scalia, tendered a request for a two year leave of absence while he goes to do his bit with Uncle Sam's Navy. A replacement will be selected in the near future.

CAROLINE COUNTY MEDICAL SOCIETY

ROBERT H. WRIGHT, M.D.

Journal Representative

The Caroline County Medical Society met at the Tidewater Inn, Easton, on July 1.

The meeting, at luncheon, was to honor Dr. H. Fletcher Silver, Goldsboro. He was presented an engraved silver tray by the members of the society with best wishes for many more years of activity.

Members absent: Dr. Charles Stonesifer and Dr. Damson George.

DORCHESTER COUNTY MEDICAL SOCIETY

ALFRED R. MARYANOV, M.D.

Journal Representative

The members of this society were deeply shocked by the sudden death of Dr. Walter B. Johnson on Friday evening, June 4, 1954. Dr. Johnson died of a coronary embolus while attending a Rotary Outing.

Dr. Johnson was secretary to the Dorchester County Medical Society, as well as Dorchester County Health Officer, since 1948. His untimely death has been deeply felt by the members of this society and his community.

At the present time, and for the next five years, the school children in Dorchester County will be undergoing a survey by dentists from The United States Public Health Service, to determine the value of fluorination of water in preventing dental caries. It has been determined that an optimal amount of fluorine is naturally present in the water supply of this county, and for this reason, Dorchester County has been chosen for the survey.

MONTGOMERY COUNTY MEDICAL SOCIETY

DEWITT E. DELAWTER, M.D.

Journal Representative

Excerpts from the minutes of May 18, 1954, meeting of the Montgomery County Medical Society.

The final meeting of the Montgomery County Medical Society before the summer season was held on May 18, 1954, at the Olney Inn. Dr. M. Sacks was the speaker on the subject "Progress in Blood Coagulation."

Business: Although the six member delegation was sent to the Spring meeting of the State Society uninstructed, they were advised that the Montgomery County Society opposed any assessment of the members for a new faculty building so long as a portion of the funds were to be used for the support

and maintenance of a library. Perhaps the assessment would be more readily accepted if someone would explain in the pages of the JOURNAL the need for the continuation of the library and its historical volumes.*

It was announced that Dr. V. L. Ellicott has resigned as county health officer after more than twenty years of service in that capacity. As yet the county authorities have not announced a successor to Dr. Ellicott.

The Montgomery County Medical Society has volunteered to supply material for one issue of the JOURNAL. Dr. James McCarrick has been appointed to take charge of collecting and organizing the material for that issue.

The tentative schedule for our fall program is as follows:

September 21, 1954

Program—Correctable Heart Disease.

Panel Discussion. Director by Dr. Proctor Harvey, Georgetown University Hospital.

Place—Olney Inn.

October 19, 1954

Program—"Infectious Hepatitis"

Place—Clinical Center, National Institutes of Health, Bethesda, Maryland.

* An Editorial explaining this matter will be published in a forthcoming JOURNAL.

November 16, 1954

Program—Dinner Dance.

Place—Woodmont Country Club.

December 21, 1954

Program—Kidney Disease. Speaker, Dr. George Shriner, Georgetown University Hospital.

Place—Olney Inn.

ST. MARY'S COUNTY MEDICAL ASSOCIATION

J. R. GUYTHER, M.D.

Journal Representative

At the April meeting of the Medical Society, the members present unanimously approved a resolution favoring the principle of free choice of physicians to all employees covered by the Workman's Compensation Law. It was noted that at the present time it is the policy of the State Industrial Accident Commission to have a designated physician care for industrial accident cases. This policy denies the patient free choice except under special circumstances.

St. Mary's County is in the midst of an active fund raising campaign with a goal of \$250,000 to finance the construction of a new wing for the St. Mary's Hospital. The campaign is being conducted by the professional fund raising firm of A. J. Hanney Association and will climax in September. A successful campaign is expected.

HOUSE COMMITTEE APPROVES NEW "PRESUMPTIVE" BILL

The AMA Washington Letter, No. 71

Chairman Edith Nourse Rogers of the House Veterans Affairs Committee is pressing for a House vote on a bill (H.R. 8789) which would increase the presumptive period for multiple sclerosis, psychoses and arthritis to three years. Currently arthritis is one year, psychoses and multiple sclerosis two. In the face of adverse reports from the Veterans Administration and the Budget Bureau, the committee on Wednesday voted out the bill. Mrs. Rogers will seek a special rule in order to get it on the House floor as soon as possible. In opposing the bill, VA Administrator Higley warned that its passage might "be urged as a precedent for extending the presumptive period for many other chronic diseases." He reminded the committee also that veterans affected would become eligible for outpatient treatment. The American Medical Association is opposed to the bill, contending that the theory of presumption of service-connection by fiat is *medically and scientifically unsound*.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

DIABETES

LOUIS KRAUSE, M.D.*

In the Papyrus Ebers of 1500 B.C., there is a prescription recommended for the purpose "to drive away the passing of too much urine." It goes on to talk about the thirst associated with increased output. This, plus the other description in the text, certainly suggests the presence of the condition that we recognize as Diabetes at this time. Then a little more than a millennium later, Aretaeus, the Cappadocian, gave a very good description of the symptoms of Diabetes, particularly stressing the increased intake of water and output of urine. The name itself in the Greek comes from this very observation: from *dia betes*—to go through like a siphon.

Another millennium later, we have a correct, but complicated description by Paracelsus in his *Tractatus III, De Diabetica*. In 1679, Thomas Willis was the first to separate the Diabetes Mellitus or sugar diabetes from Diabetes Insipidus or water diabetes. He noted that the urine in Diabetes Mellitus tasted sweet and in his words, "sweet as imbued with sugar or honey." In 1848, the Xanthoma of the Diabetes was described by Thomas Sydenham. The deep, uninterrupted regular breathing of diabetic coma was described by Adolph Kussmaul. In 1890, Oskar Minkowski and Von Mehring related the pancreas to Diabetes.

In this country in 1900 at Johns Hopkins, Opie described hyaline degeneration in the pancreas. Then in 1923, the era of Insulin began, introduced by Frederick Banting, Charles Best and MacLeod of Canada. From then on, Diabetes and its control and complications have been greatly illuminated and in the following list of books the story of "sugar diabetes" is still being unfolded.

DIABETES

Aretaeus, the Cappadocian. Extant works. London, Sydenham society, 1856.

* Chairman, Library Committee.

Paracelsus. *Opera omnia*. Genevae, I. Antonij & Samuelis De Tournes, 1658.

Willis, T. *Pharmaceutice rationalis*. London, R. Clavell, 1679.

Sydenham, T. *Opera universa*. Lugduni, Johannem a Kerchem, 1726.

Cullen, W. *First lines on the practice of physic*. Edinburgh, Wm. Creech, 1777.

Home, F. *Clinical experiments, histories & dissections*. Edinburgh, Wm. Creech, 1780.

Rollo, J. *Cases of the diabetes mellitus; with the results of the trials of certain acids, and other substances, in the cure of the lues venerea*. 2d ed., London, C. Dilly, 1798.

Grégory, G. *Elements of the theory and practice of physic*. 1st ed., London, Burgess & Hill, 1823.

Prout, W. *On the nature & treatment of stomach & renal diseases*. 4th ed., London, J. Churchill, 1843.

Camplin, J. M. *On diabetes, and its successful treatment; from the 2d Lond. ed.* New York, S. S. & W. Wood, 1861.

Harley, G. *Diabetes*. London, Walton & Maberly, 1866.

Donkin, A. S. *On the relation between diabetes & food*. New York, Putnam, 1875.

Bernard, C. *Lecons sur le diabete et la glycogenese animale*. Paris, Bailliere, 1877.

Cantani, A. *Der diabetes mellitus*. Berlin, Denicke, 1880.

Tyson, J. *Treatise on Bright's disease & diabetes*. Philadelphia, Lindsay & Blakiston, 1881.

Hirsch, A. *Handbook of geographical and historical pathology*. London, New Sydenham society, 1883-86.

Schnée, E. *Diabetes, its cause and permanent cure*. London, H. K. Lewis, 1889.

Düring, A. *Ursache und Hailung des Diabetes Mellitus. (Zucker Krankheit)*. Hannover, Schmorl & von Seefeld Nachf, 1892.

Minkowski, O. *Untersuchungen uber den Diabetes Mellitus nach Exstirpation des Pankreas*. Leipzig, F. C. W. Vogel, 1893.

Seegen, J. *Der Diabetes Mellitus auf Grundlage zahlreicher Beobachtungen dargestellt*. 3. Aufl. Berlin, A. Hirschwald, 1893.

Pavy, F. W. *The physiology of the carbohydrates, their application as food and relation to diabetes*. London, J. & A. Churchill, 1894.

- Noorden, K. H. von. *Die Zuckerkrankheit und ihre Behandlung*. Berlin, A. Hirschwald, 1895.
- Lenne, A. *Wesen, Ursache und Behandlung der Zuckerkrankheit (Diabetes Mellitus)*. Berlin, S. Karger, 1898.
- Williamson, R. T. *Diabetes mellitus and its treatment*. Edinburgh, Y. J. Pentland, 1898.
- Opie, E. L. *Disease of the pancreas, its cause and nature*. Philadelphia, Lippincott, 1903.
- Naunyn, B. *Der Diabetes Mellitus*. 2. umgearb. Aufl. Wien, Alfred Hölder, 1906.
- Pavy, F. W. *On carbohydrate metabolism*. London, J. & A. Churchill, 1906.
- Lusk, G. *Metabolism in diabetes. (The Harvey Lectures)*. Philadelphia, Lippincott, 1908-09.
- Lepine, R. *Le diabete sucre*. Paris, Bailliere, 1909.
- Noorden, K. B. von. *New aspects of diabetes; pathology and treatment*. New York, E. B. Treat, 1912.
- Allen, F. M. *Studies concerning glycosuria and diabetes*. Cambridge, Harvard Univ. Press, 1913.
- Cammidge, P. J. *Glycosuria and allied conditions*. New York, Longmans, Green, 1913.
- Hill, L. W. *The starvation treatment of diabetes, with a series of graduated diets used at the Massachusetts general hospital*. Boston, W. M. Leonard, 1915.
- Allen, F. M., Stillman, E., and Fitz, R. *Total dietary regulation in the treatment of diabetes*. New York, Rockefeller Institute for Medical Research, 1919. (Monograph no. 11)
- Banting, F. G. *The internal secretion of the pancreas*. Toronto, The University library, 1922. (Reprint from "Jour. of Lab. and Clin. Medicine," 1922.
- Joslin, E. C. *Diabetic metabolism*. Washington, Carnegie Institution of Washington, 1923. Publication no. 323.
- MacLeod, J. J. R., and Banting, F. G. *The antidiabetic functions of the pancreas and the successful isolation of the antidiabetic hormone—insulin*. St. Louis, Mosby, 1923.
- MacLeod, J. J. R. *Carbohydrate metabolism and insulin*. London, Longmans, 1926.
- McKittrick, L. S., and Root, H. F. *Diabetic surgery*. Philadelphia, Lea & Febiger, 1928.
- White, P. *Diabetes in childhood and adolescence*. Philadelphia, Lea & Febiger, 1932.
- Wilder, R. M. *Clinical diabetes mellitus and hyperinsulinism*. Philadelphia and London, Saunders, 1940.
- Duncan, G. G. *Diabetes mellitus, principles and treatment*. Philadelphia, Saunders, 1951.
- Duncan, G. G. *Diseases of metabolism*. 3d ed. Philadelphia, Saunders, 1952.
- Joslin, E. P. *The treatment of diabetes mellitus*. 9th ed. Philadelphia, Lea & Febiger, 1952.
- Warren, S. *The pathology of diabetes mellitus*. 3d ed., Philadelphia, Lea & Febiger, 1952.

BLUE SHIELD, BLUE CROSS OPPOSE TAX TREATMENT OF HEALTH PLANS

The AMA Washington Letter, No. 72

Senate Finance Committee has received strong protests from Blue Cross and Blue Shield Commissions and Associated Hospital Services of Wisconsin over two sections in the tax revision bill which they say are a threat to further growth of voluntary health insurance.

The committee's attention was called to the fact that under the bill the present tax-exempt status of all health insurance benefits would be ended. Instead, the recipient would be required to regard the payments as taxable income, unless the plan making the payment "qualifies" with the Internal Revenue Bureau. It was pointed out that the qualifying requirement probably would not be too great a burden on the larger employers "with skilled and experienced legal and personnel departments," but that the smaller employers' plans would find it practically impossible to present to the Internal Revenue the analyses and other data required to qualify the plan and thereby to relieve subscribers of tax liability for benefits received.

Commented the Blue Cross Commission: "The mere suggestion that these informal simple arrangements (for health plans) involve questions of tax liability is bound to be a serious deterrent to the making of such arrangements."

The Senate committee is now working over the House-passed measure in executive session and already has given tentative approval to liberalizing income tax deductions for medical expenses. (This particular proposal has been backed by the American Medical Association.)

Health Departments

STATE OF MARYLAND DEPARTMENT OF HEALTH MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, July 30-August 26, 1954

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County....	2	—	1	—	1	—	3	5	3	—	1	—	—	2	17	—	5	—	—
Anne Arundel.....	1	—	—	—	2	—	1	1	—	—	—	—	—	—	4	1	5	—	—
Howard	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Harford	1	—	1	—	1	—	2	1	—	—	—	—	—	—	6	—	—	e-1	—
Carroll	—	—	—	1	1	—	—	—	—	—	2	—	—	3	1	—	—	—	1
Frederick	—	—	2	8	3	—	—	—	—	—	—	1	—	—	4	3	5	—	—
Washington.....	—	—	—	1	2	—	—	—	—	—	—	—	—	2	4	—	9	—	—
Allegany.....	1	—	—	1	5	—	—	—	—	—	2	—	—	—	5	—	—	—	—
Garrett.....	—	—	—	3	1	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Montgomery.....	2	—	2	4	7	—	8	2	1	—	—	—	—	7	3	—	4	c-1	1
Prince George's.....	4	—	—	1	6	—	5	1	—	—	1	—	—	8	11	—	2	e-1	—
Calvert.....	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Charles.....	—	—	—	1	2	—	—	—	—	—	—	—	—	—	2	—	—	—	—
Saint Mary's.....	3	—	—	1	2	—	—	—	—	—	—	—	—	13	—	—	—	—	—
Cecil.....	—	—	—	—	—	—	—	2	2	—	—	—	—	—	3	—	1	—	2
Kent.....	—	—	—	—	4	—	3	—	—	—	—	—	—	2	—	—	—	—	—
Queen Anne's.....	—	—	—	—	—	—	—	—	—	—	—	—	—	2	1	—	1	—	—
Caroline.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—
Talbot.....	—	—	—	—	—	—	—	1	—	—	—	—	—	—	1	—	5	—	—
Dorchester.....	—	—	—	—	—	—	—	1	—	2	—	—	—	—	1	—	9	—	2
Wicomico.....	—	—	1	—	—	—	4	—	2	—	—	—	—	—	4	3	19	—	2
Worcester.....	—	—	—	—	3	—	—	—	—	—	—	—	—	3	2	—	1	—	—
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1	—	—
Total Counties.....	14	0	7	22	40	0	26	14	8	2	6	1	0	42	73	8	67		8
Baltimore City.....	11	0	5	2	11	0	23	7	8	1	21	0	0	49	93	5	429		11
State																			
July 30-Aug. 26, 1954.	25	0	12	24	51	0	49	21	16	3	27	1	0	91	166	13	496		19
Same period 1953.....	19	1	13	28	32	0	132	74	65	7	10	6	1	42	165	4	635		23
5-year median.....	26	1	12	—	39	2	65	62		15	14	4	3	76	211	26	716		25

Cumulative totals

State																			
Year 1954 to date....	2975	10	283	665	11346	26	2675	36	22	19	1279	12	4	612	1462	116	4741		363
Same period 1953.....	2677	9	1415	328	1454	58	2179	125	102	18	2167	19	9	217	1596	95	5219		524
5-year median.....	3024	21	936	—	4164	41	1484	98		43	858	20	26	382	1869	295	4810		412

c = congenital syphilis under 1 year of age.

e = encephalitis, infectious.

BALTIMORE CITY HEALTH DEPARTMENT

Poliomyelitis and Gamma Globulin—1954

In a recent *Saturday Letter To The Mayor* the Commissioner of Health of Baltimore reported on the current City Health Department policy with regard to the use of gamma globulin. The Health Department's position followed the action of the Maryland State Board of Health on this matter. The text of the *Saturday Letter* is as follows:

"The Honorable Arthur B. Price,
Acting Mayor of Baltimore City
City Hall
Baltimore 2, Maryland

Dear Mr. Price:

There is transmitted to you herewith the weekly Morbidity and Mortality Statistical Report of Baltimore for the week ending June 10, 1954.

Because of the general public interest in poliomyelitis at this season and the confusion in the minds of many regarding gamma globulin I believe you will be interested in the letter I sent yesterday to all physicians in Baltimore relative to this matter. The letter is as follows:

'June 10, 1954

Dear Doctor:

Much thought has been given during recent weeks by the State, City and County Health Departments to the puzzle presented by the availability of gamma globulin this summer, and its apparent lack of proven value in relation to preventing or modifying poliomyelitis.

You will remember that in the press dispatches of

May 6 the public was informed of the action taken on this matter by the State Board of Health as follows:

The Maryland State Board of Health at its meeting of April 14, 1954, studied the "Summary Report of the National Advisory Committee for the Evaluation of Gamma Globulin in the Prophylaxis of Poliomyelitis in 1953" as published in the Journal of the American Medical Association of March 27, 1954. It was the considered opinion of the Board that no present evidence existed from the 1953 tests, as set forth in the "Summary Report," that Gamma Globulin is of value in the prevention or modification of poliomyelitis.

Nevertheless, since there is at present some division of opinion on this matter, and since Gamma Globulin will be available in 1954, the Maryland State Department of Health will supply Gamma Globulin to practicing physicians on their request after consultation with the local health officer, if, in the judgment of the physician, he wishes to use it.

Enclosed for your information is the stencilled matter on Gamma Globulin—1954 recently prepared by the Maryland State Department of Health, and an editorial on the Polio-Gamma Globulin situation from the April 29, 1954 issue of the New England Journal of Medicine.

In view of the present situation the Baltimore City Health Department will not encourage the use of gamma globulin in connection with poliomyelitis in 1954.'

Very truly yours,

Huntington Williams, M.D.

Commissioner of Health"

MEDICAL REPRESENTATIVES ASSOCIATION

The Medical Representatives Association of Baltimore, Maryland, an association of Medical representatives, as a service to the Medical and Allied professions have compiled, printed and are now distributing to each physician practicing in the Baltimore and Metropolitan area, a directory. This directory lists the names, addresses and phone numbers of medical representatives assigned to the Baltimore area.

Every effort has been made on the part of the association to make this directory as complete as possible so that a physician may contact a representative for information concerning his products. Distribution of the directory will be made in person to each physician, where possible.



Blue Cross - Blue Shield



HEALTH SERVICE, INC.—THE NATIONAL BLUE CROSS ORGANIZATION

R. H. DABNEY*

In an industrial age when large firms have employees scattered across the nation, there is a demand for coverage of all employees under uniform hospitalization benefits at uniform rates. This demand stemmed principally from those organizations whose employees were members of the large national unions, and where the employer contributed to the cost of hospitalization coverage.

To meet this problem and to help local Plans enroll and service large national accounts, Blue Cross Plans in 1949 organized Health Service, Incorporated, a stock insurance company wholly owned by the Blue Cross Association, a non-profit corporation established on authority of the Blue Cross Commission. Blue Cross Plans contributed the funds for the necessary working capital and paid-in surplus of the corporation, much in the same manner as hospitals loaned funds to get the Blue Cross Plans started. By virtue of their contributed capital, the Blue Cross Plans elect ten of the fifteen directors of Health Service, the other five being appointed by the Blue Cross Association.

Here's how Health Service works. A large organization with branches and operations in many different states requests Blue Cross coverage for all of its employees, specifically the *service benefits* which only Blue Cross can provide. Health Service works out a basic contract, with benefits fitted to the company's needs, and develops a uniform rate for the contract based on the rates of each local Blue Cross Plan involved. Health Service handles the enrollment of the group, with assistance locally where necessary, and collects the payroll-deducted subscription rates through one master bill to the company's home office.

Insofar as possible, Health Service "farms out" the coverage to the local Blue Cross Plans in whose areas the employees are located. In Maryland, for

* R. H. Dabney, Director, Maryland Hospital Service, Inc., Maryland Medical Service, Inc.

example, we would underwrite the coverage to the extent of our regular benefits, and receive from Health Service our regular rates for those benefits. When the basic national contract is broader than our own, we would provide the extra benefits as required, but be fully reimbursed by Health Service. In this way, the subscriber always receives the full benefits under his basic national contract; administratively, the cost is underwritten jointly by Health Service and the local Plan.

Health Service is more flexible than most local Blue Cross Plans, and employers can have a fairly wide choice of benefits to suit their needs. For example, contracts may offer full service benefits for 30 days, 70 days, or even 120 days. Maternity may be provided on a flat indemnity basis, \$80 most frequently, or on a full service basis. Private room allowances may vary, too. With respect to outpatient coverage and exclusions, the contracts follow an established pattern.

To make the Health Service program work requires the cooperation of all Blue Cross Plans, as well as all the member hospitals of each Plan. The subscriber carries a special Health Service membership card, which carries the name of his local Blue Cross Plan, and member hospitals handle the admissions just as if he were a local subscriber. Hospitals here have cooperated with us 100% on these special accounts, and largely because of this, our experience with Health Service groups has been excellent. We now have 30 of these groups enrolled locally, covering some 1,842 contracts and 4,672 subscribers.

There is also a similar national organization for surgical-medical coverage—Medical Indemnity of America—organized by the Blue Shield Plans. There is a joint administrative staff for both organizations, and contracts are handled together when the additional surgical-medical coverage is desired. Because of wide variations in service coverages under local Blue Shield Plans, however, arrangements for local participation cannot be worked out in most areas. Eventually, it is hoped that this can be arranged in a manner similar to Health Service.

Maryland Academy of General Practice

Executive Secretary—MR. WILLIAM J. WISCOTT, 3722 Greenmount Avenue, Baltimore

SIXTH ANNUAL SCIENTIFIC ASSEMBLY, LORD BALTIMORE HOTEL, OCTOBER 21, 1954

Another instructive day-long program of post-graduate lectures has been arranged by the Program Committee, Dr. Lauriston L. Keown, Chairman, and Dr. Charles F. O'Donnell, Co-Chairman. The annual banquet will be held in the evening; the principal address will be given by Dr. Edward J. Stieglitz, Physician, Lecturer, and Editor, of Washington, D. C.

Six outstanding clinicians and teachers will address the Academy—coming from Cleveland, New York, Boston, Philadelphia—on problems in medicine, surgery, dermatology, neurology, ophthalmology and pediatrics. They will present timely and practical information on "Advancement in Therapy of Chronic Emphysema," "Changing Trends in Abdominal Surgery," "Dermatology in General Practice," "Parkinson's Disease and Its Treatment," "Some Common Diseases of the Eye," and "Regurgitation in Infants."

All members of the Medical and Chirurgical Faculty, as well as all medical residents and interns in Maryland hospitals, are cordially invited to attend this Sixth Annual Scientific Assembly of the Maryland Academy. There is no registration fee for the Scientific program.

The Committee urges that the physicians bring their wives. An interesting program, including luncheon, is being arranged for them. Tickets for the reception and banquet may be obtained from Mr. Wm. J. Wiscott, 3722 Greenmount Avenue, Baltimore 18, at a charge of \$7.00 per plate for physicians, and \$5.00 for their wives.

PROGRAM

9:00-10:00 Registration—Caswell Room

Morning Session

Moderator—Dr. Nathan E. Needle

10:00 A.M. "Some Common Diseases of the Eye and Their Treatment."

Dr. Roy O. Scholz,

Instructor Ophthalmology, Johns Hop-

kins University Medical School, Baltimore.

11:00 A.M. "Changing Trends in Abdominal Surgery."

Dr. George Crile, Jr.,

Surgeon, Cleveland Clinical Foundation Hospital, Cleveland.

12:00-1:00 P.M.—Lunch

Afternoon Session I

Moderator—Dr. Norman E. Sartorius, Jr.

1:00 P.M.—*In Memoriam*

Necrology by Dr. Philibert Artigiani.

1:15 P.M.—"Parkinson's Disease and its Management."

Dr. Lewis J. Doshay

Associate Attending Neurologist, Neurological Institute, New York.

2:15 P.M.—"Recent Advancements in the Therapy of Chronic Pulmonary Emphysema."

Dr. Maurice S. Segal, M.D.,

Clinical Professor of Medicine, Tufts College, Medical School, Boston.

3:15 P.M.—Recess

Afternoon Session II

Moderator—R. Van L. Campbell, M.D.

3:30 P.M.—"Dermatology in General Practice."

Dr. Donald M. Pillsbury,

Professor of Dermatology and Syphilology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.

4:30 P.M.—"Regurgitation in Infants."

Dr. John Edmund Bradley,

Professor and Head of Department of Pediatrics, Medical School, University of Maryland, Baltimore.

6:30 P.M.—Reception & Cocktails

7:15 P.M.—Banquet

Dr. Lauriston L. Keown, presiding

Principal speaker, Edward J. Stieglitz, M.D.

Music

Note: *Members of the Maryland Academy who attend this assembly will receive credit for 6½ hours of formal post-graduate study.*

ANNUAL BUSINESS MEETING

The Annual Meeting of the Academy will be held in the Lord Baltimore Hotel promptly at 8:15 P.M., Wednesday, October 20th. Business to be transacted includes reports of the officers and committees, elections of officers and new business. All *members are urged to be present.*

NEW MEMBERS

Since our last meeting the following physicians have been elected into *active* membership:

Samuel Allen, 18 Fawcett St. Kensington	Morris J. Baylin 5418 Park Heights Ave. Baltimore 15
William H. F. Warthen Balto. Co. Health Dept. County Office Building Towson 4	Gordon Wm. Kelley 6124 41st Ave. Hyattsville
Abram Goldman 206 S. Gilmore Street Baltimore 23	Huntington Williams Baltimore City Health Dept. Baltimore 3
Louis F. Klimes 2623 E. Monument St. Baltimore 5	Leonard H. Golombeck 7013 Liberty Road Baltimore 7
John Charles Hyle 7527 Belair Road Baltimore 6	J. Ralph Horky Churchville

Lee Bruner Snow
9013 Flower Ave.
Silver Spring

Edward Wilson Ditto,
III
217 W. Washington St.
Hagerstown

John Milton Wyman
7659 Old Georgetown
Rd.
Bethesda

Katherine A. Chapman
3924 Baltimore St.
Kensington

MEMBERSHIP REQUIREMENTS

The prerequisites for becoming a member of the Academy are simply that the physician must belong to the Medical and Chirurgical Faculty of Maryland, and must devote the greater part of his time to the general practice of medicine. Any doctor who has practiced medicine for 30 years or more, or who has attained the age of 70, is eligible to emeritus membership.

One of the chief aims of the A.A.G.P. is to maintain postgraduate education. Each member of the Academy must during each 3-year period, report 150 hours of medical study to be eligible for re-election to membership. One hundred of the 150 hours can be made up by attendance of national, state and local medical society scientific meetings and at regular hospital staff clinical meetings. The remaining 50 hours must be for attendance at formal study courses such as are offered as post-graduate courses at various medical schools and approved hospitals, or such as the scientific meetings sponsored several times a year by the Maryland Academy of General Practice. Actually, during a 3-year period, a busy doctor who cannot get away for prolonged postgraduate courses, can receive enough credit by full attendance at these one-day scientific assemblies.

\$3 MILLION MORE ASKED FOR VA

A. M. A. Washington Letter, No. 77

President Eisenhower has requested Congress to appropriate an additional \$3 million for Veterans Administration's inpatient care program for next fiscal year. It would be added to the regular appropriation which already has passed Congress. The President said the money would be needed because of an increasing patient load, the early opening of new psychiatric hospitals, and the necessity to avoid reducing hospital employment "to a degree which would impair present standards of medical care." The President's request came four days after VA Administrator Higley had suggested \$6 million was needed.

Specialties

MARYLAND RADIOLOGICAL SOCIETY

RICHARD B. HANCHETT, M.D.

At the Second Annual Meeting of the Maryland Radiological Society, Dr. E. Thrall Campbell was elected President; Dr. Webster H. Brown, Vice President; Dr. Paul W. Roman, Secretary-treasurer; and Dr. Richard B. Hanchett, Councilor for the American College of Radiology of Maryland.

The Second Annual Meeting of the Maryland Radiological Society was held at the Hotel Alexander in Hagerstown, Maryland, on Saturday, May 15, 1954. This meeting was attended by a large number of Maryland radiologists with their wives and guests.

Registration was 10:30 a.m. and following this there was a lengthy business meeting and business luncheon. A report on the "Economics of the Practice of Radiology" was presented by a committee consisting of Dr. Paul Roman as Chairman and Dr. J. Howard Franz and Dr. John DeCarlo as members. This report established in a statistical manner the great increase in the amount of x-ray equipment owned by general practitioners and specialists other than radiologists and also a strong trend toward concentration of diagnostic radiological procedures in hospitals. It was voted to continue the work of this committee and to develop as clearly as possible the present position of the practice of radiology to the general practice of medicine.

Dr. Stanley H. Macht reported a statistical survey of the present status of the mal-practice insurance coverage in Maryland as it affects radiologists. This study developed the very significant fact that there was an extremely low claim rate against well trained radiologists. It was voted to continue this study and to correlate the findings with those available in the American Medical Association and in the American College of Radiology.

Dr. E. Thrall Campbell then presented a resolution concerning the relation of the practice of the medical specialty of Radiology to the corporate practice of Medicine in hospitals and the place of Radiology in the Blue Cross, Blue Shield and other insurance programs. After some discussion, this resolution was unanimously approved.

The scientific portion of the program consisted of companion papers on Progress in Radiology. A paper was given in each Radiation Therapy and Diagnostic Roentgenology. Dr. Robert J. Dickson, radiotherapist at the Johns Hopkins Hospital and formerly radiotherapist at the Hammersmith Hospital in London, England, read a paper on "Recent Trends in Radiotherapy." This was discussed by Dr. Harry A. Miller, attending radiologist at the Sinai Hospital in Baltimore. Dr. Theodore F. Hilbish, chief of diagnostic roentgenology of the National Institute of Health, then read a paper, "Recent Trends in Diagnostic Roentgenology." This paper was discussed by Dr. John DeCarlo, chief radiologist at the Baltimore City Hospital. It is expected that these papers will be published later in the Maryland State Medical Journal.

A reception, cocktails and dinner followed later in the day. The guests of honor were Dr. B. B. Kneisley, president of the Medical and Chirurgical Faculty and Mrs. Kneisley.

Following dinner, the meeting was climaxed with the showing of the color motion picture, the recently declassified "Operation Ivy," the explosion of the hydrogen bomb in the Pacific. Dr. Ralph E. Lapp, well-known nuclear physicist, then gave the principal address of the meeting on "Atomic Defense" and emphasized the immediate need for dispersion of industry and active, vigorous civil defense planning.

A special program for the women was arranged by Mrs. E. Thrall Campbell.

Ancillary News

NURSING SECTION

M. RUTH MOUBRAY, R.N., *Executive Secretary,*
Maryland State Nurses Association

THE NURSING AIDE PROJECT IN MARYLAND*

Hospital administrators and nursing service directors throughout the country have often expressed a need for better trained auxiliary personnel as a means of improving patient care. The Nursing Aide Project is a program recently devised to meet this need. Through it, workshops are held for instructors in hospitals and nursing homes to teach them how to conduct a training program for auxiliary personnel in their own institutions.

The Nursing Aide Project was planned and is co-sponsored by the American Hospital Association, the Department of Hospital Nursing of the National League for Nursing, and the United States Public Health Service. The Department of Hospital Nursing of the National League for Nursing has the responsibility of assisting local areas in adapting the project to their particular needs.

In October, 1953 the National League for Nursing held a meeting of representatives from Maryland, Delaware, and the District of Columbia in order to outline the proposed program to them and to ask their interest in participating in the project and in serving as a pilot area. Included in this meeting were representatives of the Maryland-District of Columbia-Delaware Hospital Association, the State Leagues for Nursing, the State Nurses Associations, the State Departments of Health, and the State Boards of Nurse Examiners. The group unanimously agreed that the project was much needed and that Maryland, Delaware, and the District of Columbia would participate in the program, serving as a pilot area.

Mrs. Barbara S. Howell, Chairman of the Steering Committee of the Department of Hospital Nursing, Maryland League for Nursing, was elected Chairman of the Nursing Aide Project in Maryland. She had

spent the past four years as Assistant Director of Nursing Service in a Baltimore hospital and was well aware of the problems in providing nursing care for patients in the area. She also had worked closely with the training program for aides and orderlies in the hospital where she was employed.

After the initial October meeting, the program in Maryland moved along swiftly. Funds to finance the project were obtained from two sources: the Department of Vocational Education, Maryland State Department of Education, which provided funds to pay for training time, and the Maryland-District of Columbia-Delaware Hospital Association, which provided funds for traveling expenses in conducting the program.

It was agreed that three teacher-trainers would be adequate for Maryland, and Mrs. Howell, Chairman of the program, agreed to serve also as teacher-trainer for the area of Baltimore City and the surrounding communities. Miss Rose Marie Bishop was selected for the Eastern Shore, and Mrs. Ora Mae Lewis was selected for Western Maryland. The National League for Nursing, responsible for preparing these teacher-trainers for their jobs, secured Mr. Dwight P. Jacobus to conduct an institute for teacher-trainers in the Maryland, District of Columbia, Delaware area. Mr. Jacobus as Supervisor of Educational Services to Industry, Maryland State Department of Education, is well-known for his ability as an on-the-job training expert.

It was decided that a pilot workshop should be held prior to the institute, and this was done late in December. The participants selected for this workshop were from the various types of institutions, as well as from institutions which were anxious to have a training program. All teacher-trainers from Maryland, the District of Columbia, and Delaware then attended a five-day institute, receiving instruction and practice in the procedure to use in

* Submitted by the Maryland League for Nursing.

workshops for instructors. The teacher-trainers then returned to their assigned areas to begin the task of holding two-day workshops for instructors of auxiliary personnel in hospitals and nursing homes.

In Maryland the response from hospitals to the program has been most gratifying. Numerous two-day workshops have been held, and in many cases, hospitals have sent additional participants after their original participants had returned and reported the values received. All participants in the workshops have been enthusiastic, and this has undoubtedly contributed to the continued interest of the institutions which they represent. The participation of nursing homes in Maryland has been less favorable than that of hospitals, but the enthusiasm of those who have responded and the use to which they have put the information and material received show the value of such a program to their needs. Currently, Mrs. Howell is devoting much time and effort to arousing interest in the program among nursing homes and hospitals which have not as yet participated. The Maryland State Department of Health has also been asked to assist in stimulating interest among nursing homes in the state.

The two-day workshops in Maryland have been conducted whenever possible with homogeneous groups, that is, hospital instructors together and nursing home instructors together, so that problems of common interest can be discussed. Active

participation of all is very essential, and a common background is helpful in drawing the entire group into the discussions. However, in small Maryland communities where this policy has not been adhered to, no difficulty has developed in the sharing of problems. The size of the group is important also, since the techniques to be learned require individual practice. Therefore, a maximum number of ten participants is recommended.

Follow-up visits to each institution sending a participant to one of the workshops are a vital part of the total program. The purpose of the follow-up is two-fold: first, to see whether the institution has been able to complete a "skill-inventory" of its non-professional personnel; and second, to learn whether it has been able to apply the teaching method as learned and practiced at the workshop. The length of time and number of these follow-up visits varies with the size of the institution and the time required to complete the ground work. In some instances one visit has served, and in others a second visit has been necessary after the classes have actually started.

The Department of Hospital Nursing of the National League for Nursing has worked very closely with our pilot area and has given invaluable assistance in every way. It is hoped that their observations will be of value in launching the project throughout the country.

WHO ASSEMBLY VOTES INCREASED BUDGET OVER U. S. PROTESTS

The AMA Washington Letter, No. 72

The 7th World Health Assembly has voted a \$9.5 million budget for World Health Organization programs for 1955. This is an increase of \$1 million over this year but \$800,000 under the recommended figure. Delegates voted approval at Geneva after turning down a U. S. proposal that the budget be held to \$8,607,000. According to a Pan American Sanitary Bureau account of the meeting, Dr. Frederick J. Brady, head of the U. S. delegation, declared the U. S. was strongly opposed to any budget that would bring this country's contribution beyond the \$3 million ceiling set by Congress.

Dr. Brady said that this country does not want to find itself "forced into a position of having to depart from a long tradition of faithfully honoring such obligations." The U. S. contribution to WHO has been running around a third of the total budget.



PHARMACY SECTION



CONTROLLING DISPENSING OF DRUGS

L. M. KANTNER, PHAR. D.*

On April 14, 1954 the following regulation, effective June 15, 1954, governing the labeling of prescriptions for drugs (other than narcotic drugs) that may be dispensed only on prescription was adopted by the State Board of Health.

"For those drugs that may be dispensed only on prescription, unless the prescriber has authorized refilling a definite number of times, the container in which such drug is dispensed shall be labeled with the following or similar wording, in addition to the directions for use": "This prescription cannot be refilled except on the prescriber's authorization to the pharmacist."

In connection with this regulation the following letter was sent to every pharmacy in the State:

"Enclosed is a copy of a regulation adopted by the State Board of Health on April 14, to become effective June 15, 1954.

There are two reasons for adopting this regulation. The first is that when persons obtain prescriptions, to which the regulation applies, they are informed upon delivery, as they should be, that the prescription cannot be refilled until the pharmacist obtains the prescriber's authorization.

The second and primary reason for the regulation is because of reports, from authentic sources, that some pharmacists are disregarding the provisions of both the Federal Durham-Humphrey Act and the State Dangerous Drug Act, as these laws apply to refilling prescriptions for legend drugs.

Prescriptions, for legend drugs, that fail to carry authorization to refill a definite number of times indicate, without question, the prescribers did not intend that the patients be supplied more of the medication than the amount prescribed.

* Secretary, Maryland Board of Pharmacy.

Notwithstanding the therapeutic benefits being derived from the drugs predominantly used today, there are numerous instances where they have untoward effects, some minor, while others are quite serious.

It can be charged that pharmacists who refill prescriptions for legend drugs without the prescriber's authorization are both counter-prescribing and selling legend drugs over-the-counter.

There can be no question but that the majority of pharmacists recognize their moral and legal responsibilities in dispensing drugs and medicines, and they should be protected against those whose ethics can be questioned in safeguarding the public and the maintenance of professional standards.

What should not be lost sight of is that, under the legislation upon which this regulation is based, the penalty for violation is from \$250.00 to \$500.00."

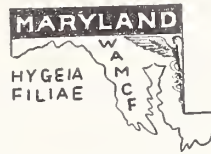
Further comment as to the reason for this regulation would be superfluous. It cannot be denied that physicians are being annoyed and often irritated because of pharmacists calling them to obtain their authorization to refill a prescription. The physician should realize however the pharmacist has no other alternative. Likewise pharmacists also are annoyed and irritated because frequently they are required to make several calls before they can contact the prescriber.

If a pharmacist illegally refills a prescription, and that is the charge, if he ignores legal requirements and a patient suffers damage from use of the prescription, the pharmacist is not only subject to prosecution but to a damage suit as well. As has been pointed out in these columns previously, physicians can save themselves annoyance from pharmacists' telephone calls relative to refilling a prescription, if they would indicate on their prescription to refill a definite number of times or denote not to refill.

A number of physicians are making this a practice and find it most satisfactory.



Woman's Auxiliary Medical and Chirurgical Faculty



MRS. JOHN G. BALL, *Auxiliary Editor*

SEMIANNUAL MEETING PROGRAM

HAGERSTOWN, MARYLAND

HOTEL ALEXANDER, CHALET ROOM

THURSDAY, SEPTEMBER 30, 1954

- | | |
|-----------------------|--|
| 10:00 a.m. | Registration |
| 10:30 a.m.-12:00 noon | General Meeting
<i>Speaker:</i> Mr. John M. Martin, Secretary, Committee on Legislation, A. M. A. |
| 12:30 p.m.- 2:00 p.m. | Luncheon with the doctors. |
| After 2:00 p.m. | Tours: (Meet in the Maryland Room)
Washington County Museum of Fine Arts and Hager House
"Antiquing"
Brandt Furniture Company
Moeller Organ Factory
Pangborn Corporation
Bridge or Canasta, Maryland Room, Hotel Alexander |
| 4:30 p.m.- 6:00 p.m. | Reception and Cocktail Party, Main Ballroom. |

See your husband's program for further information and reservations.

REPORT OF NATIONAL CONVENTION OF THE WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION, SAN FRANCISCO, CALIFORNIA, JUNE 21-25, 1954

MRS. ALBERT E. GOLDSTEIN,
PRESIDENTIAL DELEGATE

The Convention schedule began Monday, June 21, 1954 at 9 a.m. with Round Table Discussions on Legislation, Program, Mental Health, Nurse Recruitment, "Today's Health" and Public Relations. The National Chairmen of these committees conducted Round Table Discussions and had speakers to talk on the progress of their work.

Mrs. Edgar Quayle, Chairman of Legislation, introduced Mr. Joseph Stetler from that department of the A. M. A. He discussed subjects that had been of interest throughout the year, among them, The Bricker Amendment, The Veterans

Medical Care Program, Medical Health Insurance and the Federal Social Security Taxation Program for Doctors. Our state had given support to the A. M. A. on all of these debatable questions. The change of administration has not solved the problems of federal expansion into all phases of business, including medicine. We must continue to learn the facts and be able to discuss such bills intelligently. The dangers in many "give-away" bills are not apparent and merit thoughtful consideration.

Dr. Leo Bartemeier, Chairman of the A. M. A. Health Committee, said doctors' wives throughout the nation are going to be asked to translate a truism into practical action. They will try to attack mental health problems at their obvious starting point—with very young children.

Mrs. Richard Stover conducted "Today's Health" Program. Cash awards were made to Utah, Kansas and Arizona for securing the most subscriptions to "Today's Health." A total of

38,189 subscriptions to this magazine was reported for the year. This figure represents an increase of 5,683 over last year. An increase in circulation would increase the advertising potential and cut the magazine overhead. "Today's Health" Chairmen watch for renewal time of your subscribers, canvass doctors and dentists in your county, and suggest gift subscriptions for new mothers. The year 1953 was the best in 25 years of "Today's Health" publication.

Mrs. Harold Johnson conducted the Nurse Recruitment Program and gave praise to Maryland for the work we accomplished in forming 30 Future Nurses Clubs. Our film, "The Girl with the Lamp," was mentioned in several state reports as having been purchased or borrowed for their Auxiliary use. Our "Future Nurses Convention" was cited as a most worthy effort for Nurse Recruitment.

Tuesday, June 22, 1954

After roll call by the Constitutional Secretary, Mrs. George H. Yeager, at which time we had 5 members present, we heard the President's address. After reporting the many accomplishments of the National Auxiliary, our President stated that Highway Safety has become her chief interest. She will turn her attention to that upon retirement from the A. M. A. Auxiliary Office. Noting that traffic killed more Americans last year than the Korean War did, Mrs. Schaefer said she "will work to save healthy life as well as diseased life."

The morning meeting then adjourned for lunch and a fashion show, at the Mark Hopkins Hotel. The guest speaker, Lynn T. White, Jr., Ph.D., President of Mills College, gave an interesting historical talk on "The Changing Past." Dr. White said, "History has long been written by the thin upper crust, the literate 5%, of the population while the long ignored 95% of illiterate peasantry produced the sub-history of the ages. There is no past. Only our present thinking of what has gone before us. The past is changing just as fast as the art of medicine is changing."

The afternoon session opened with the state reports; Eastern Region came first. Maryland was proud to make an outstanding one on Nurse Recruitment, the organization of Wicomico County Auxiliary and a permanent Doctor's Day, March 30, by Governor's Proclamation. Our A.M.E.F.

contribution enabled us to receive a special honor, a certificate of achievement. Mrs. Frank Gastineau, National Chairman, requested and set a goal of \$1.00 average contribution per member in each state. Maryland contributed \$2.25 a member and was presented with a certificate of merit. Only six certificates were presented.

Wednesday, June 23, 1954

An impressive "In Memorial" service was conducted by Mrs. C. R. Pearson. State reports of the North Central Region and reports of Chairmen of Special Committees followed.

Civil Defense. Medical care is the most vital of all phases of national defense. An effective program is the duty of the Auxiliary. See that your doctor husband knows his place in the county Civil Defense plan.

Nurse Recruitment. Mrs. Harold Johnson, National Chairman, praised the work of Maryland and felt that we had made an outstanding contribution to Nurse Recruitment.

At the luncheon in honor of Mrs. Leo J. Schaefer, President and Mrs. George Turner, President-Elect, the American Medical Education Foundation was presented with memorial funds totaling \$8,000 by the Auxiliary. Two \$100 presentations were made to the "World Medical Association" and the "Committee on Careers in Nursing" by the Auxiliary. State reports continued through the afternoon.

Thursday, June 24, 1954

The morning consisted of Election of Officers, followed by Installation of Officers, presentation of the President's Pin and Mrs. George Turner's Inaugural address.

On Thursday evening the Annual Dinner was held at the Fairmont Hotel. A clever skit, entitled "There Is a Doctor in the House!," written by Mrs. James Phalen, a member, and presented by the members of the San Francisco Auxiliary, was much enjoyed.

Friday, June 25, 1954

Mrs. George Turner, the newly elected National President, talked to Presidents and Presidents-Elect of the states. She repeated the words of the past presidents by saying, "Again this year we will light our candles from the torch of our predecessors."

Her keynote this year is "Health Service in Communities." She mentioned six points necessary to create a good leader: (1) Enthusiasm; (2) Knowledge (Enthusiasm being placed ahead of knowledge); (3) Confidence; (4) Hard work; (5) One who can make decisions; (6) One who is unafraid.

Dr. Howard, Secretary of the A. M. A., talked on the accomplishments of the House of Delegates of the A. M. A. Mrs. Leo J. Schaefer met with the House of Delegates, this being the first time an Auxiliary President has appeared. The National Osteopathic Association has asked for recognition by the A. M. A. The A. M. A. asked for permission to study the curriculum and campus of the six schools in the country before making a decision. The Osteopathic Association has not yet agreed to that. Until they do, the A. M. A. will make no amalgamations or decisions. Dr. Howard spoke of unethical medical procedures such as panel systems tied up with advertising. No decision on this question was made, as it was turned over to the Board.

Last year 257 bills were studied that had medical implications. Do not think the fight against socialized medicine has been won. A change of legislation has not solved the problem. We are urged to read our material from the A. M. A. and when our State Chairman on Legislation asks us to write our Congressmen, it is important that we do, as Congress speaks only one language, "Register and Vote." They are beginning to have respect for the A. M. A. They realize it *is* the voice of the Doctors. Congress did not accept the A. M. A. recommendations on Social Security of Doctors until letters came in by the hundreds from Doctors throughout the country.

Mr. Jones talked on A. M. E. F. and he stated \$805,000 was raised from January to June of 1954; \$56,000 from Auxiliaries. Seventy-nine medical schools in 56 cities supply the need of the nation. Many states use memorial cards as a means of raising funds for A. M. E. F. Mrs. Frank Gastineau, National Chairman, asked for a dollar a member from each state. Maryland averaged \$2.25 a member.

Mr. Edlow talked on the publication of "Today's Health" which is the only authentic health magazine published today. Mrs. Richard Stover, National Chairman, has new ideas and wishes to get the material into the hands of the State Chairmen.

Mrs. Henry from the National Committee on Careers in Nursing talked. She said we are getting nurses but need more. We have 330,000 graduate nurses, 76,000 practical nurses and 102,000 in nursing in the country. We need 50,000 professional nurses and 15,000 practical nurses each year. Last year we had 43,000 professional and 9,000 practical nurses graduate. They asked state chairmen to ally with Careers in Nursing.

An amendment was proposed by the A. M. A. and read before our body to be passed upon. It was introduced into the A. M. A. through the Academy of General Practice. It concerned doctors and their families. They sponsor a "Physician For Every Doctor" and asked the wives of physicians to urge their husbands to have yearly physical examinations. This amendment was originated by a physician in Washington State who felt if, he had checked on his own health, he might have learned that he had cancer of the lung before it was too late.

Like the cobbler's children who have no shoes, the doctor's family may get the poorest medical care and attention, says the American Academy of General Practice. To combat this situation, the Academy has launched a nationwide project best described by its slogan, "A Family Doctor for Every Doctor's Family." Ironically, the project's sponsor, Dr. Merrill Shaw, Seattle, Washington, vice president of the Academy, is dying of cancer. The project is the last of his many contributions to medicine.

The Academy has asked women's auxiliaries of state and county medical societies and the American Medical Association to help sponsor the project. Its goal is to see that doctors and their families receive better medical care.

Dr. Shaw is convinced that physicians and their families receive "hop-skotch" medical attention, neglect their own health, and seldom have a thorough check-up. Those who consult specialists tend to forget that each specialist knows only a small part of a patient's complete medical history. During his twenty years as a general practitioner, Dr. Shaw does not recall that a single doctor ever came to him for a physical examination.

Records show that the country is losing many highly-trained doctors at the peak of their careers. Much of this loss is due to preventable illness. As

pointed out in a recent monthly publication, more than half the doctors in private practice work sixty or more hours a week. Their failure to practice what they preach gives them a death rate higher than other professional men. Heart ailments are the doctor's occupational disease.

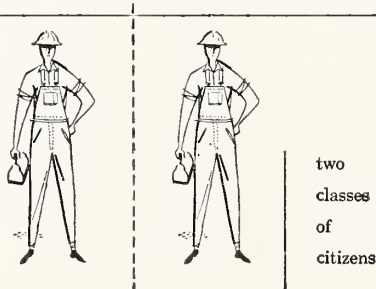
FEDERAL WORKERS HEALTH INSURANCE PLAN PRESENTED

A. M. A. Washington Letter, No. 81

The administration's plan for contributory health insurance for 2.3 million federal civilian employees was presented to Congress July 22. The Civil Service Commission, in submitting the plan to Post Office and Civil Service Committees of the Senate and House, said it was part of President Eisenhower's 9-point program for "a well-rounded federal career system." Each agency would be authorized to negotiate with commercial or non-profit hospitalization and medical care plans for their employees and dependents on a voluntary basis. The government would contribute up to \$26 annually for each worker who would pay the remainder on a payroll deduction basis. The commission estimates the annual cost to the government at \$60 million. The final plan was formulated under the direction of Nelson Rockefeller, Under-secretary of the Department of Health, Education, and Welfare. Commission officials said legislation was being presented now for study in preparation for action in the Congress convening in January.

In Viewing the VA Medical Program . . .

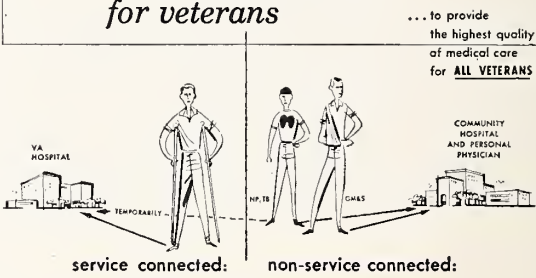
*effects of
present veterans medical legislation*



It is the belief of the medical profession that it is unsound to authorize free lifetime medical care for veterans who suffered no mishap in uniform, while other citizens with no military background must pay their own way. Although the two men above are identical, they represent "two classes of citizens"—the veteran with no service-connected disability who is granted medical care at federal expense, and the non-veteran who must personally assume responsibility for his medical care.

In Viewing the VA Medical Program . . .

*the
medical profession's policy
on medical care
for veterans*



The medical profession stands for the highest quality medical care for all citizens. Veterans, as citizens, should accept the responsibility for their own health needs—unless they became disabled as a result of military service; then it is the responsibility of the Veterans Administration to provide medical care and hospitalization. Because many communities do not as yet have adequate facilities to care for war veterans with non-service-connected tuberculosis or neuropsychiatric disorders, the medical profession recommends that the VA continue—on a temporary basis—to treat these patients.

Coming Meetings

WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

MRS. E. RODERICK SHIPLEY, *President*

MRS. JOHN B. DEHOFF, *Secretary*

MRS. WHITMER B. FIROR, *Treasurer*

Wednesday, October 6, 1954, 11:00 a.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Poliomyelitis—The Present Status. Edward Davens, M.D., Chief of the Bureau of Preventive Medicine, Maryland State Department of Health.

CANCER SECTION

HOWARD D. FISHBURN, M.D., *Chairman*

ARTHUR G. SIWINSKI, M.D., *Secretary*

Wednesday, October 13, 1954

National Cancer Institute, Bethesda

Details of the programs will be sent to regular members. Anyone else interested may call the secretary at Ve 7-5797.

JOINT MEETING OF THE ORTHOPEDIC SECTION AND THE BALTIMORE SECTION OF THE RADIOLOGICAL SOCIETY

ALLEN F. VOSHELL, M.D., *Chairman*

WILLIAM P. HORTON, M.D., *Secretary*

JOHN DE CARLO, M.D., *Chairman*

PAUL N. ROMAN, M.D., *Secretary*

Tuesday, October 19, 1954, Marine Hospital

Cocktails 5:30 p.m.

Dinner 6:00 p.m.

Scientific Meeting 8:00 p.m.

Discussion of Bone Tumors. H. L. Jaffe, M.D., Guest Speaker

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty.

RICHARD W. TELINDE, M.D., *Chairman*

BEVERLEY C. COMPTON, M.D., *Secretary*

1211 Cathedral Street, Baltimore

Thursday, October 21, 1954

5:00 to 6:00 p.m.

SECTION OF GENERAL PRACTICE

LOUIS R. MASER, M.D., *Chairman*

K. KENNETH KRULEVITZ, M.D., *Secretary*

1211 Cathedral Street, Baltimore

Thursday, October 28, 1954, 9:30 p.m.

The General Practitioner's Relation to the Patient. Louis Krause, M.D.

AMERICAN COLLEGE OF CHEST PHYSICIANS

October 31, 1954

The Potomac and Virginia Chapters of the American College of Chest Physicians will hold a joint meeting, opening at 9:30 a.m., Sunday, October 31, 1954, at the Shoreham Hotel, Washington, D. C.

All physicians are cordially invited to attend. There is no registration fee for guests or members.

The program will include symposia on Cardiac Surgery and Bronchogenic Carcinoma, a panel discussion on Problems Encountered in the Present Day Management of Tuberculosis and round table luncheons on Pulmonary Emphysema and Evaluation of Patients for Cardiac Surgery.

OPHTHALMOLOGICAL SECTION

FRED M. REESE, M.D., *Chairman*HERMAN K. GOLDBERG, M.D., *Secretary*

Hopkins Club

Friday evening, November 19, 1954

Dinner 6:15 p.m.

Meeting 8:00 p.m.

Dr. William F. Hughes, Jr. will speak on "Diagnosis of Intraocular Tumors."

A.M.A. NEWS RELEASE—WASHINGTON OFFICE

THE MONTH IN WASHINGTON

Washington, D. C.—While Congress didn't enact all the health bills President Eisenhower's administration wanted to put through, it did mark up an imposing record of accomplishment. In fact it passed more health and medical legislation than any Congress in many, many years. The AMA actively supported most of the bills finally enacted, and opposed none of them.

Four important new laws were written into the statutes before the session ended—expansion of the Hill-Burton hospital construction program, expansion of the vocational rehabilitation program, amendment of the income tax law to allow more liberal deductions for medical expenses, and transfer of the responsibility for health of the Indians to U. S. Public Health Service.

For years a group of state health officers have been working to bring about the transfer of Indian hospital and medical service from the Indian Bureau in the Department of the Interior to Public Health Service in what is now the Department of Health, Education, and Welfare. The health officers could show beyond any question that the Indians were receiving far less medical care than the rest of the population. They maintained that if the Public Health Service were made responsible for the Indians' health, there would be a rapid change for the better on the reservations.

What might be called governmental inertia succeeded in holding up the legislation for a time, but this Congress decided to make a shift. Public Health Service, which will take over on the reservations next July 1, already has plans under way to insure the Indians more and better medical care.

The demands for a more dynamic vocational rehabilitation program have been building up outside the federal government as well as in Washington. The problem facing this admin-

istration was to get more people rehabilitated but at the same time to induce the states to take a more active part in the work. The law now enacted promises to do this. It authorizes gradual increases in the federal appropriations, but at the same time is aimed at bringing the states up to the position of full financial partners by the end of five years. The goal is to rehabilitate at least 200,000 persons annually, in place of the present 60,000.

If local communities are willing to raise from one-third to one-half of the cost, the new Hill-Burton program should result in the construction, within three years, of possibly a half billion dollars in new facilities—rehabilitation centers, diagnostic-treatment clinics, chronic disease hospitals, and nursing homes. (This program was discussed in detail last month in this space.) The new construction will be in addition to the continuing Hill-Burton grants for complete hospitals.

On the medical cost deduction question, too, economists long have felt that families with unusually large medical expenses should be given more liberal tax deductions. The new law will allow them to deduct medical expenses in excess of three per cent of taxable income. Under the old law the figure was five per cent. A \$3,000-income family with \$150 in medical expenses under the old law could deduct nothing, but under the new law \$60. The Treasury estimates that the total saving to families will be \$30 million.

The general public probably read and heard more about the one bill that was defeated—reinsurance—than it did about all the health and medical legislation that passed. That defeat (in the House) was a surprise and a disappointment to the President. His advisors might have told him that all was not well, but obviously they did not. Opposition was not confined to the AMA. Also lined up against it were most of the health insurance companies, the U. S. Chamber of Commerce and a number of other professional groups. The labor unions would accept it, but wouldn't work to get it. Most significant of all, it had lukewarm support at best from the lawmakers who know most about it, the Senate and House committees that conducted the hearings.

PHS ALLOCATES 60% OF CURRENT YEAR'S RESEARCH FUNDS

The AMA Washington Letter, No. 83

Sixty per cent of the Public Health Service medical grant money appropriated to the National Institutes of Health for fiscal 1955 already has been allocated. Approximately one-third of the 1,442 research awards went to new projects and the remainder for continuing existing studies. The grants, totaling \$14,685,671, are for "basic and applied research in the major diseases afflicting Americans today."

Of the seven Institutes of Health, the National Cancer Institute distributed the largest number of new grants: 92, totaling \$981,074. Chemotherapy of leukemia and allied forms of cancer was listed as a typical subject of NCI research. The National Heart Institute has the largest number of continuation grants: 213, totaling \$2,283,370. Scientific investigations of NHI include effects of hormones on hardening of the arteries, edema mechanisms occurring in heart failure, synthesis of compounds acting on the heart, and effects of temperature and humidity on the circulatory system. A total of \$33,918,000 was appropriated for PHS medical research for the current fiscal year.

REQUEST FOR USED MEDICAL JOURNALS, ETC.

ST. GEORGE'S MISSION HOSPITAL

Punalur, P. O., Travancore, S. India

Dr. T. K. Thomas,
Hon. Medical Superintendent.

Punalur,
20th February '54

Ref:

To

Secretary, Medical and Chirurgical Faculty of Maryland,
1211 Cathedral Street, Baltimore, Maryland,
U.S.A.

Gentleman,

I wish to inform you that the above Hospital is a non-profit organization situated in a hilly village and working among the poor labour classes of the locality and its suburbs. As good medical literatures are very few in this part of the world, a small library is started recently attached to the above Hospital with the idea of collecting used medical journals, books, bulletins, reprints of articles and Transactions of Medical Societies from all available sources in foreign countries so that up-to-date knowledge in Medical Practice may be obtained.

Further Ayurvedic and Unani systems of Medicine are very troublesome competitors to Allopathic system here and proper equipments and medical literatures are highly essential for the successful management of the Hospital.

In the light of the above circumstances, I request you to kindly issue a News Note in your monthly Bulletin and also in your Society Medical Journal requesting the sympathetic members of your Society to send me their used medical journals with all available backward copies, Medical books, reprints of articles and other useful medical literatures and also second-hand Surgical Instruments, Medical Appliances, Laboratory equipments etc., so that many of our poor patients may directly and indirectly be benefitted by them.

This Act of Kindness and Charity by the members of your Society will ever be remembered which lapse of time cannot wipe away from our memory.

Thanking you very much for all your valuable services,

Yours Very Truly,
T. K. Thomas
Hon. Medical Superintendent.

* * * * *

POLIO VACCINE TRIAL NEEDS PHYSICIANS' AID AS IT MOVES INTO
EVALUATION PHASE

More than 600,000 children have completed three inoculations, in the field test of the trial polio vaccine developed by Dr. Jonas E. Salk of the University of Pittsburgh. The emphasis now shifts to the evaluation study under the direction of Dr. Thomas Francis, Jr., University of Michigan School of Public Health. The validity of the evaluation is dependent upon data gathered on poliomyelitis cases in the test groups, *including those children in the first three grades who did not get vaccine.*

In addition, data on cases among family members of participating children are an integral part of the study. Since the number of poliomyelitis cases among the test groups may not be large, it is essential that all cases are completely reported. Early diagnosis, prompt reporting and follow-up, and the securing of *necessary epidemiological information and laboratory specimens* are important factors in the evaluation.

An outline of procedures and copies of necessary forms have been sent to local and state health authorities. It is important that physicians in areas where vaccinations were not given, cooperate in the study by notifying local or state health officers of cases occurring among children who participated in the trials and then migrated to another area and children who go to summer camps. Local health officials also need information on participating children who receive injections of Gamma Globulin.

This phase of the study will depend, to a large degree, on the wholehearted cooperation of practicing physicians.

Maryland

STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 3

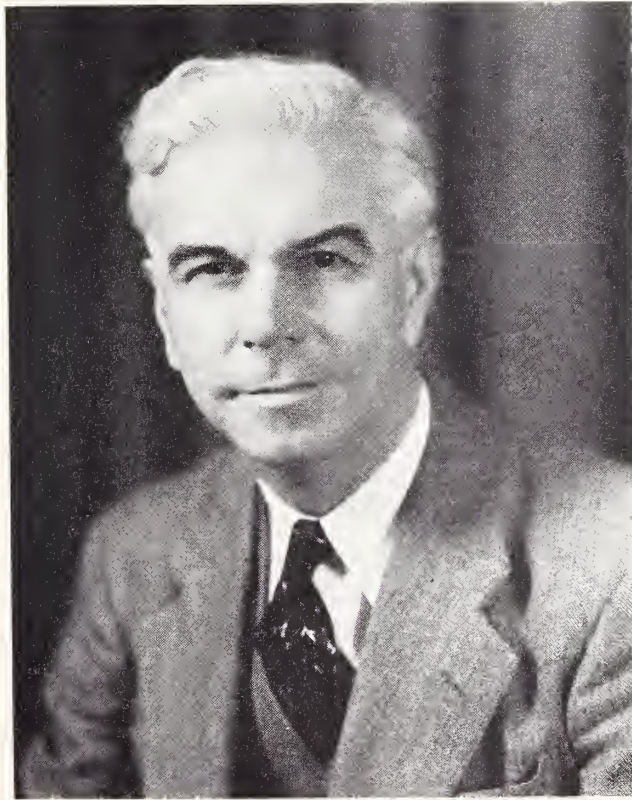
October, 1954

NUMBER 10

EDITORIAL—The Library's Importance

LOUIS KRAUSE, M.D.*

To grow up in an atmosphere of books is indeed a privilege. Those who have had this opportunity should be ever grateful. There is something friendly about books; they appeal to the emotions, possibly even more than to one's intelligence.



DR. LOUIS KRAUSE

Books, like friends, are constant, and never fail us. As we grow older our libraries become a greater source of comfort to us, because we realize that we are joining the older generation. One turns to his books to learn of the past, to get ideas or

*Chairman, Library Committee, Medical and Chirurgical Faculty of the State of Maryland.

opinions of the present, and to look for signs of what the future may bring. Patrick Henry's statement is very true: "I know no way to judge the future but by the past." The farther in the past we can look, the farther in the future we can see.

The founders of New England were a practical people whose first thought was their defense, their second: "that good learning should not perish from among us." The maintenance of a well-equipped library should be an important enterprise of any city. In a medical center, a superior library should be an obligation. A college and medical school training are an excellent thing, but the better part of every man's education is that which he acquires by himself. A good library should furnish the opportunity and the material. One is haunted by Koheleth: "And, further, by these, my son, be admonished: of making many books there is no end; and much study is a weariness of the flesh." Today, cataloging in the libraries has become almost a science, and stacks of books are no longer a labyrinth. One finds guideposts at every turn in a well organized library. While this help does not imply a shortcut to learning since that is impossible, it does, however, offer a shortcut to information that will make learning more accessible. Every book we read should become a rung in the ever ascending ladder by which we climb to knowledge. A profitable way to spend time is to browse in a library. One cannot limit the joys of the infinite treasure of books. "If you approach them, they are not asleep; if you question them, they conceal nothing; if you mistake them, they never grumble; if you are ignorant, they will not laugh at you."

Most of us in medicine are craftsmen, and books in great measure are our tools. It is therefore, important for us to have adequate tools, improving them as the frontier of knowledge advances. Much of our knowledge today is the result of our increased precision in our tools. For this reason, I believe the support of the medical library is very necessary. It is distressing to see how frequently the practitioner ceases to continue his medical education after he is graduated. Fortunately, this is becoming less true as postgraduate instruction is increased. For those who are not interested in supporting a large reference and consulting library, it is imperative that they have their own library. However, this is not often the case. Only too frequently the material appurtenances of living are stressed, but a well used library helps to keep life sweet as we grow old.

One can readily distinguish between the doctor who is keeping one foot in the library and is constantly in touch with the current medical literature, as contrasted to the doctor who has little or no interest in medical literature. Throughout the ages, one sees landmarks of medicine being made by the doctors who are interested in their practice, and in medical literature.

The Medical and Chirurgical Faculty at its outset dedicated itself to the improvement of its members. This certainly was the spark or germ that initiated the collection of books that we have in the library.

There is need for a place where all members of the medical profession can obtain easy access to any medical literature, where the latest medical information can be displayed. Nothing illuminates a people like scholars, and a library surely

helps to produce them. Certainly a physician of common sense without erudition is better than a learned one without common sense, but the thorough master in his chosen field must have learning in addition to his natural gifts. It is a short sighted policy to maintain books of only practical utility. Our book shelves should contain many volumes that will be used only by a certain class of medical scholars. It is very true that there is a dead medical literature and a living one; the dead isn't all ancient, nor the living all modern, and there is none living or dead which cannot teach something, even as an autopsy teaches medicine. It is with the living literature that the medical practitioner is first concerned. Thus a library to meet the needs of our time must subscribe to a great number of periodicals in our own and other languages. Such a large number of periodicals no private library would have need of nor wish for. This certainly will bring about an opportunity for a well rounded knowledge. Isn't it disturbing to hear constantly in our present culture, the flippant wisecracks and half knowledge bandied about? We must accept whatever good that may be obtained from it, but to use the old imagery, we must keep it under control as we do weeds in a lawn by enriching the soil and sowing good seed in the form of good teaching and good books rather than wasting our time talking about it. Half knowledge can only be conquered by whole knowledge.

The periodic journals are not the only important kind of writing. Much of what is in a journal is crude and unsound. Only too often many of us remain under the influence of the last article we have read as a woman under the sway of the latest fashion. There is a difference between seasoned and unseasoned knowledge. So, it is well to have both kinds available. The shelves of our library must offer the greatest hospitality to a variety of subjects. Some books have written words of wisdom of the framework of the time in which they were written, but have ceased to be oracles. Some never had any important burden. Apart from any practical value of older writings isn't it a pleasure to read the accounts of great discoverers in their own words and language and their problems? Many an ancient volume is of practical value and will never grow old. There comes a time when every book in the library is wanted by somebody. A few days ago a celebrated physician and author in another country asked for books on a certain subject. It was with great satisfaction that he was referred to our collection. Our shelves must also extend space to a class of works which we consider outside the purview of modern medicine. I refer to the various cults, such as the Adventists, spiritualists, and are they not worthy of our philosophic study? True they belong to a class of minds with which we must be patient while their Maker sees fit to grant their existence. With all their skill, our practitioners need a library like ours. Our liberal profession could still use more erudition. This would be reflected by the public; no one will deny that the public needs more instruction on the subject of health and disease. How frequently we see the people victimized and preyed upon by every kind of imposition. The ignorances and prejudices of the populace react upon the profession to the harm of both.

Our Medical and Chirurgical Faculty Library is peculiarly equipped with information about the local history of the medical profession in Maryland. How

comforting it was for our Library Staff to supply the history of the early days of medicine for counties in the past year, to wit—Dorchester and Montgomery! It was a source of inestimable satisfaction to the Staff. This local history was not to be had in the Library of Congress or the Army Medical Library.

Our Library then is like a temple that should be consecrated as a cathedral dedicated to the advancement of sound knowledge and the study of man, his physical, mental, spiritual and social natures. This will increase our efforts to relieve suffering, to promote a good public relationship with each member of the profession and the public with special emphasis for those who are promoting the well being of their fellow men. We certainly can restate the ancient proverbs:

“Receive my instruction, and not silver; and knowledge rather than choice gold. For wisdom is better than rubies; and all the things that may be desired are not to be compared to it.”

“And they that be wise shall shine as the brightness of the firmament; and they that turn many to righteousness as the stars for ever and ever.”

**MEDICAL AND CHIRURGICAL FACULTY
BLUE CROSS AND BLUE SHIELD ENROLLMENT**

The annual Blue Cross and Blue Shield enrollment period for you and your employees will take place during the month of November. During this period, applications will be accepted for new subscribers, as well as for present subscribers who desire a change in coverage. In October, before the enrollment period opens, you will receive full information covering the details of the enrollment, along with application cards and descriptive folders from the Maryland Hospital Service, Inc. and the Maryland Medical Service, Inc.

Reports

THE SAN FRANCISCO CONVENTION

HOWARD M. BUBERT, M.D.*

For a novice delegate, participation in a convention of the American Medical Association is a revealing, impressive, and arresting experience for several reasons. The first is the tremendous size of the entire affair, which gives one almost a feeling of awe—not only of the meeting itself—but of the power and size of an organization capable of such an effort.



A.M.A. Convention Headquarters, San Francisco, California, 1954

The 1954 annual meeting held this year in San Francisco was the 103rd of the Association, and the eighth and largest held in that city. There were 12,063 physicians registered, of whom 148 were from outside of the United States. The total registration exceeded 34,000, including families of the physicians registered, nurses, medical students, exhibitors and other interested persons.

The scientific exhibits numbered 222 and were varied and wide in scope. About 300 papers were presented to the general and special meetings and some of these, as we all know, attracted wide interest in the public lay press.

* Dr. Howard M. Bubert and Dr. Warde B. Allan are the delegates who represent the Medical and Chirurgical Faculty in the House of Delegates of the A.M.A.

Little purpose would be served here in discussing the details of the meeting because these have been adequately covered in a series of articles that have appeared in recent weeks in the *Journal of the American Medical Association*. Using my own experience as a guide, it seemed to me that it might be worth while to explain the organizational operations of the Association because rarely do members who have had no official connection with The Association "see the wheels go around." This was to me highly instructive and I trust will be interesting to the readers of this JOURNAL.

When one attends an A.M.A. Convention as a member of the House of Delegates, it soon becomes apparent that this group represents the hard central core of the entire organization just as Congress does in the government of this Country. Obviously it would be impractical for any legislative group to have administrative responsibilities; consequently a rather elaborate administrative structure has been evolved over the years—a structure designed to implement and carry out the policies and decisions of the legislative group.

The House of Delegates consists of representatives from the component state societies as well as the Canal Zone, Alaska, Hawaii and Puerto Rico. The sections also have delegates as do the Armed Services and the Public Health Service.

The first obligation facing the delegate is the establishment of his credentials and this is done very quickly so that the House can begin work promptly, which is a prime necessity because of the great volume of resolutions and reports that must receive consideration in the limited period of time available. The body is under the extremely able leadership of the Speaker, Dr. James Reuling of Bayside, New York, assisted by his equally able associate, Dr. Vincent Askey, of Los Angeles, Vice-Speaker.

As the meeting gets organized and underway it soon becomes evident that—like the United States Senate—it is a club even though not "the most exclusive one in the world," and many of the members are back after having served previous terms and having made contacts and friendships that are so essential if a member of a legislative body is to be an effectual representative of the organization which sent him to the meeting. One soon becomes impressed with the fact that he has joined a body of serious, intelligent and competent men intent upon doing a good job.

The Speaker, Dr. Reuling, soon impresses one with his efficiency, his knowledge of parliamentary procedures, his good humor and his grim determination to fight the clock and complete the business of The House as expeditiously as possible. Some conception of the task that he faced is gained when one considers that ninety resolutions were offered for consideration, a few of which were highly controversial and capable of arousing considerable emotional response upon the part of both proponents and opponents. This work load, of course, did not include the reports of the Board of Trustees, the different Councils, the officers, and speeches by the retiring and incoming presidents.

There was a strict rule that all resolutions must be in the hands of the Secretary before the sessions began and, needless to say, this was honored in the breach by many: causing the speaker to say rather ruefully, "It is only a pious hope that this has been accomplished."

Each resolution and report was referred by the Speaker to an appropriate "Reference Committee" for careful consideration, following which they reported back to the House, giving a discussion of each together with recommendations. These were usually followed. This is a particularly important phase of the plan of operation of the House, because by segmentation time is saved and small informal hearings are possible. Anyone interested in any particular phase of the work is free to appear before the reference committee concerned and present his views, thus insuring a forum for all.

The writer was impressed by the fact that the senior delegate from Maryland, Dr. Warde Allan, had over the years obtained the respect and liking not only of the Headquarters staff but also of the members of the House of Delegates, and that he was becoming an increasingly valuable representative from our State.

The National Organization wields a tremendous influence on the national scene, particularly as regards Washington, which now plays such a dominant role in our daily life. Because the number of delegates from a state depends upon membership—one per thousand or fraction thereof—Maryland actually should have three instead of two if more members belonged to the A.M.A. This seems a "must" to me and I believe all of us should assist in attaining our full representation so that we may have the greatest voice possible in the affairs of the Association.

COMMITTEE FOR THE STUDY OF PELVIC CANCER*

BEVERLEY C. COMPTON, M.D., *Secretary*

Abstracts of Case Discussions:

1. S. L. Colored. Age: 46 years. Widow. Para 1. Bilateral salpingectomy and appendectomy at age 20 years. Periods always somewhat irregular. For the past two years very heavy flow, and for the past year many clots. Intermenstrual bleeding for about one year before coming to the hospital. Consulted doctor A late in 1951—pelvic examination made—treated with oral medication, medicine for “nerves,” etc. Told that she was having the menopause. Patient remained under care of doctor A until May 1952. June 1952, consulted doctor B. Pelvic examination made. Patient told that she had a fibroid tumor and that she was in the menopause. The patient states that she consulted doctor B every 2–3 weeks. Because of the persistent intermenstrual bleeding, patient was referred to the hospital in October of 1952.

Diagnosis: Squamous cell carcinoma of the cervix, I. C., stage I.

Treatment: Radium 4320 mgm. hours. Deep x-ray therapy.

Chairman: From the information we have there appears to have been delay on the part of doctor A and also doctor B. Although pelvic examination was made and the patient found to have a fibroid, the history of intermenstrual bleeding should have been indication for further investigation.

Visiting physician: This patient was first seen by me on June 23, 1952. A complete physical including a pelvic examination was done at that time. She had a large fibroid uterus. There was no lesion visible on the cervix and the report sent to me by the hospital indicates that no lesion was visible at the time of their first examination in the clinic. It has been my experience that patients with myomatous uteri often have irregular bleeding. The patient had told me that in 1950 she had some irregular bleeding following a normal period and that a diagnostic D. & C. had been done at that time at another hospital. Because the irregular bleeding persisted and because the patient herself had a fear of cancer I referred her to the hospital in late September, 1952. The hospital reported that the lesion was an early one.

Chairman: I think the only criticism here is that one should be very careful in assuming that the cause of irregular bleeding is a fibroid. It is fortunate that

the diagnosis was made in this case while the disease was still early. We use the classification “delay” if there has been a lapse of more than one month from the time the patient consulted a physician until the diagnosis is made or the patient referred for further study.

Visiting physician: You mean “delay” because the diagnosis could have been made earlier?

Chairman: That is right.

Committee member: It is interesting that this patient had a diagnostic D. & C. in 1950. The patient apparently did not give this information in her history at the second hospital. It would be interesting to look up this record.

(The record of this operation was subsequently checked. A D. & C. and biopsy had been done in January of 1949. The pathological report of the biopsy was *Carcinoma-in-situ, cervix*. Every possible effort was made at this time to get the patient to return to the hospital for further study but she refused although the situation was fully explained to her. Because of the above findings, the case was presented at a later meeting as of interest because of the lapse of time between the original diagnosis and treatment, and the fact that the case was still a stage I at the time of treatment. Review of the original slide of January 1949 had confirmed the diagnosis of carcinoma-in-situ.)

2. K. B. Colored. Age: 34 years. Widow. Para 2. Periods said to be regular. No intermenstrual bleeding. Patient first seen in gyn. clinic in 1945 for chronic P.I.D. Seen in September 1948, July 1949, January and February 1952, for exacerbations of P.I.D. Several visits to the clinic May–November 1953, with complaint of incapacitating pain, recurrent. It was recommended that the patient have a pelvic clean-out. She was admitted to the hospital December 1, 1953. Biopsy of the cervix revealed carcinoma, which was classified as stage I, early. A modified Wertheim hysterectomy was recommended. At operation, December 9th, a bilateral salpingo-oophorectomy was done but the uterus and cervix were not removed because of question of right broad ligament involvement with carcinoma. The pathological report: “Fibrous tissue with slight chronic inflammation, right broad ligament—no tumor.” The patient was subsequently treated with radium and deep x-ray therapy.

Committee member: This cervical carcinoma was picked up on routine biopsy on admission to the

* Under the auspices of the Medical and Chirurgical Faculty and the Maryland Division of the American Cancer Society.

hospital. It is the routine procedure that a cervical biopsy is done on every patient scheduled for hysterectomy. The sections showed very early stromal invasion and although it is not the usual procedure at this hospital to treat a stage I by operation, it was felt that this was a very early lesion and that a modified Wertheim was indicated. At operation a wide band of inflammatory tissue was encountered and it was decided that the wiser course was to remove only the tubes and ovaries. It was felt that if this was carcinoma it could not be cured by operation. If it was not carcinoma the cervix could be treated equally well by radiation. When the pathology was found to be negative, the patient was treated with radium and deep x-ray therapy.

Visiting surgeon: Not as a criticism but as a point of interest, had any biopsies been taken during the time the patient was followed in the clinic?

Committee member: I am sorry that I do not have the complete hospital record here today but it is my impression that biopsy had not been done previous to hospital admission. The cervix appeared negative.

Visiting surgeon: I do not feel that there can be any criticism of the treatment in this case. Too often a total hysterectomy is done even though the cancerous process is found to be more extensive than was thought pre-operatively, and then there is nothing left to work with.

All present at the meeting agreed that in view of the findings at operation, the procedure followed was the wise choice.

3. L. B. Colored. Age: 50 years. Married. Para 0. Menopause, 1949. January 1952, patient began to have moderately profuse whitish vaginal discharge and intermittent spotting which gradually increased in amount. Consulted doctor A in February 1952. Pelvic examination made. Patient told that she was having "the change." Treated with injections of penicillin. As the symptoms persisted and increased, the patient consulted doctor A about once a month for four or five months—was examined and assured that symptoms were due to the menopause. October 1952, spotting or moderate bleeding daily, and dull lower abdominal pain. December, bleeding became more profuse and patient went to the hospital clinic January 14, 1953.

Diagnosis: Epidermoid carcinoma of the cervix, I. C., stage III.

Treatment: Deep x-ray therapy. Radium.

Chairman: Is there any further information available on this case?

Committee member: Our information is substantially as given in the abstract. The lesion was far advanced when first seen in the clinic.

Chairman: There appears to have been considerable delay in this case. The patient was first seen by a physician in February of 1952 but was not diagnosed until January of 1953. Without much doubt this year made the difference between stage I and stage III. Apparently in this case repeated pelvic examinations were made but the diagnosis missed.

4. C. S. Colored. Age: 58 years. Married. Para 5. Supravaginal hysterectomy 24 years ago. Patient known to have had high blood pressure for some time—under care of doctor A because of this. Late December 1953, following a fall, patient had an episode of moderate vaginal bleeding. Reported this to doctor A—pelvic examination made and said to be negative. Continued to have slight bleeding about one day a week. Beginning in February, a white vaginal discharge. Reported the continued bleeding and discharge to doctor A, and told him that she had heard this sometimes meant cancer. He advised the patient to go to the hospital clinic. Because of various family problems the patient did not go to the clinic until May 12, following an episode of rather profuse bleeding.

Diagnosis: Carcinoma of the cervical stump, I. C., III.

Treatment: Deep x-ray therapy. Radium.

Chairman: Doctor A is unable to attend the meeting today but we have the following information from him:

The patient first complained of vaginal bleeding, following a fall, in November 1953. She was not examined at this time because she was bleeding. When she returned later in the month she was not bleeding and a pelvic examination was made which revealed an "eroded-looking cervix but nothing definite." No medication or treatment. The patient again complained of bleeding in February of 1954 when examination revealed a lesion definitely suspicious of malignancy and the patient was advised to go to the hospital. She was seen several times during February in regard to blood pressure and was again advised to go to the hospital.

Committee member: Here again we have a case where the patient was not examined because she was bleeding. In this case the patient returned without too much delay and was examined although the malignancy was not detected. Even though the examination appeared negative, at least a Papanicolaou smear would seem to have been indicated.

Had this been done the patient might have come to treatment earlier.

Committee member: This situation where a woman is not examined because she is bleeding is one of the things that comes to the attention of this Committee most frequently. We have discussed it many times but can emphasize again that this is never a reason for not examining a patient.

Chairman: There was certainly a large element of patient delay in this case—a delay of almost three months from the time she was advised to go to the hospital until she was seen in the clinic. There also appears to have been some delay in referring the patient for further investigation.

5. C. W. White. Age: 49 years. Married. Para 2. Beginning in the summer of 1952, periods irregular. January–September 1953, no regular periods but very slight spotting about once a month. Patient's chief complaint during this time was extreme nervousness. She consulted doctor A at frequent intervals. Symptoms said to be menopausal. Patient treated once a month with injections. Late September 1953, very profuse bleeding and the patient was sent into the hospital for biopsy. Referred to second hospital for treatment.

Diagnosis: Squamous cell carcinoma, cervix, I. C., stage IV.

Treatment: Deep x-ray therapy. Radium.

Chairman: We have written to doctor A for further information regarding this patient but unfortunately we have not received a reply.

Visiting surgeon: Our history is about as given in the abstract. The disease was very far advanced, with involvement of the bladder, at the time the patient was referred to us for treatment.

Committee member: From the information we have

it appears that the patient was treated over a rather long period of time without complete examination, on the assumption that the symptoms were menopausal. However, the patient was sent into the hospital promptly at the time of the first episode of profuse bleeding.

6. M. L. White. Age: 33 years. Married. Para 3. Periods always somewhat irregular. April 1953, brownish vaginal discharge and vulval itching. Consulted doctor A—Papanicolaou smear and biopsy taken. Biopsy said to show intraepithelial carcinoma. Repeat biopsies, May 22nd and June 26th, were also interpreted as showing intraepithelial carcinoma. The patient was referred to the hospital clinic and admitted to the hospital, July 13th, for sharp conization. On July 15th, the patient had a panhysterectomy. Pathology at the time of operation: Chronic cervicitis with focal basal cell hyperactivity and one focus suggestive but not fully characteristic for carcinoma-in-situ.

Chairman: There is, of course, no question of delay here. This is another case where a very early carcinoma was picked up promptly. The patient was followed closely and all the right things seem to have been done. Is there any further information.

Visiting surgeon: This is one of our cases. The pathology at the time of conization showed basal cell hyperactivity and the pathologist felt that the patient should have been followed for a longer time before surgery. The gynecological staff, however, felt that all evidence seemed to point to carcinoma-in-situ and we went ahead with the panhysterectomy.

There was discussion of the diagnosis and treatment of carcinoma-in-situ.

DRAFT BOARDS TOLD TO RECHECK RESIDENCY DEFERMENTS

A. M. A. Washington Letter, No. 79

The National Advisory Committee to Selective Service is concerned because some young physicians, deferred the past 12 months for residencies and internships, are delaying application for commissions. Involved are priority 1 and 2 men and those in priority 3 who are 31 years or under. These groups, the committee has informed selective service, are most urgently needed to meet calls for this fiscal year to avoid calls on priority 3 men over 31. Adds the committee: "It is essential, with few exceptions, that those who do not apply for commissions should at least have their 2-A classifications terminated." This would make them eligible for immediate induction.

Scientific Papers

THE HERNIA PROBLEM:

The Role of the Internist and General Practitioner

AMOS R. KOONTZ, M.D.*

My first operative case, when I started in the practice of surgery, was that of an elderly gentleman with a hernia, who was referred by a close friend and classmate of mine. The patient was a friend of us both. Imagine my chagrin when the hernia recurred a few months later. Naturally, the patient was discouraged and never had another operation.

What was the cause of this failure in a comparatively simple inguinal hernia? I believe that there are two reasons for it.

In the first place, I am sure that at that time, without realizing it, I treated the hernia in a rather casual manner, as a great many people do. This in spite of the fact that Halsted had been my professor of surgery in medical school, although I had not had my hospital training under him. I had operated on many hernias during my surgical residency, but had not had an opportunity to follow them up. This first private case, however, was a lesson to me and never since have I been the least bit casual about any hernia repair, but have constantly been seeking more knowledge as to the cause of hernial recurrences, and have been applying all the knowledge I could get as meticulously as I could at the operating table.

Undoubtedly another reason for the failure in my first case in private practice was the fact that this elderly man had had his hernia for a great many years and that operation had never been advised until it became strangulated, which was the case when I operated upon him. Not only

was the hernia strangulated, but with the long period of time and the advancing years, the patient's tissues were not as good as they would have been had he been operated upon years earlier. He had been wearing a truss for ten years.

The operative repair of hernia in well trained surgeons has now advanced to the point that it is no longer the main factor in the hernia problem. What then is the main factor? I believe that the answer is *delay*. Why isn't such a factor easily eliminated? I believe that the trouble lies with the average doctor who first sees the patient with a hernia. It is true that many of them immediately send their patients to a surgeon. It is also true that many of them do not. Some treat the hernia with indifference and say, "Oh, you have a hernia. Why don't you get a truss?", and then do not even bother to see whether the patient's truss is properly fitted or not. Others say, "Oh, you have a hernia. You may have to have it operated upon some day but you needn't bother about it now."

Just recently a man of 26 was sent to me by one of our leading general practitioners. The patient had a postoperative hernia of twelve years' duration in a McBurney incision. A loop of bowel was out in the hernia sac and the hernia opening was only large enough to admit the end of the index finger. Fortunately the patient had always been able to push the bowel back. However, such a hernia is the type most likely to become strangulated. Yet before this patient was finally sent to a surgeon by a doctor who realized the implications of his condition, he had been seen by

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three other doctors, all of whom advised against operation. One of them even had said to him, "Don't bother it until it bothers you." It could be contended with some justification that such an attitude borders on malpractice. As a matter of fact, the attitude is the result of a lack of knowledge of the hernia subject and this is astounding when one considers how common this ailment is.

It should be pointed out that *now* is the time to operate on any hernia. When they are first discovered, they are generally easy to cure. The longer they go, the larger they get and the more contracted and thinned out become the tissues surrounding the defect. A great many of the patients treated in the casual and offhand manner indicated above are young or middle-aged men. A great many of them go until they reach the 70's or 80's and then the hernias become so large and the tissues so relaxed, that they cannot be retained by trusses. Partial intestinal obstruction and threatened strangulation often supervenes. Thus, these patients are forced into operation at an advanced age when they are not in as good a condition and when the hernias are much harder to cure. Besides they have gone through many years of discomfort when they could have had an early operation and have avoided all those uncomfortable years.

Some of the internists and general practitioners who have this casual attitude towards hernia are among our very best doctors. Why then the casual attitude? In the first place, I do not believe that the subject of hernia is properly taught in the average medical school, although I believe that the instruction is improving yearly. Certainly there is still room for improvement. In the second place, a great many doctors are averse to operations unless they are absolutely necessary. So are we all. The question is when are they absolutely necessary. Considering how simple the operation for early hernia is and the many things that may happen to neglected hernias, it is my feeling that the operation for hernia is a *must* in the early stages unless there is some real contra-

indication. The contraindications, with the many greatly improved methods of modern anesthesia, are now few and far between.

There are some indications for operation for hernia which are more urgent than others. For instance, if the patient has an inguinal hernia which has been incarcerated once, even though it may eventually slip back by itself or be pushed back by manipulation, the condition may occur very soon again and at the second incarceration strangulation may occur necessitating an emergency operation. After one such warning, the operation should be performed as an elective procedure, as emergency procedures are never as satisfactory, even under the best conditions, as elective operations.

Femoral hernias should be operated upon as soon as possible after they appear. About 40% of femoral hernias become strangulated sooner or later and the mortality rate is high in strangulated femoral hernias, because gangrene quickly ensues due to the rigidity of the environs of the femoral canal (1).

Ventral hernias of all sorts (incisional, umbilical, and epigastric in particular) should be operated upon early, as they tend to get larger, and when they are large they are difficult to cure. In these hernias Shelley (2) found a recurrence rate of 16.8%. Burdick, Gillespie and Higinbotham (3) reported an even less satisfactory experience. Barrow (4) states that when these patients have to have a second operation, they are five times as hard to cure as at the time of primary repair.

There have been many papers in the last few years (5, 6, 7, 8, 9, 10) to show that elderly patients stand elective operations about as well as middle-aged patients, but that they do not stand emergency operations anything like so well. Certainly, therefore, hernias in elderly patients should be operated upon as elective procedures. They do very well indeed, in spite of concomitant ailments. Stewart and Alfano (11) have recently pointed out that these patients should have adequate surgical care not merely to save life but also to relieve discomfort and disability.

SUMMARY

1. Too few doctors tell their patients in the prime of life, as soon as the diagnosis of hernia is made, that they should be operated upon as soon as they can conveniently arrange it. If that were routine practice, complications of hernia would be rare and the recurrence rate would be materially reduced, because hernias would come to operation early when they are relatively easily cured.

2. Early elective operations should be performed on femoral hernias due to the high incidence of strangulation with its attendant high mortality rate.

3. Elderly patients stand elective operations well, but tolerate emergency operations poorly. Therefore, their hernias should be operated upon before they have an opportunity to become strangulated.

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OTOLARYNGOLOGY IN GENERAL PRACTICE

BENJAMIN S. RICH, M.D.*

It is an established fact that acute diseases of the upper respiratory tract account for a large percentage of the patients of general practitioners and also those of pediatricians. It is my purpose in this article to give helpful suggestions until someone finds a cure for the common cold.

First let us consider ordinary acute rhinitis which is the precursor of most respiratory complications. After considerable trial and error I'm sure each has a pet treatment for this condition and one is probably as good as the other. However, let me make a few suggestions. Do not employ antibiotics until signs of secondary involvement appear and these signs

are easily recognized. The use of such antibiotics will mask the recession or progression of the infection. Frequent cases of chronic infection of the nasopharynx as well as chronic serous otitis media have sprung from premature treatment with antibiotics. It has been my experience that the use of antihistamines with or without the usual Aspirin-Phenacetin-Codeine combination is most effective in most cases of acute rhinitis. Once started they should not be discontinued for at least three days. Of course, bed rest, a well heated room, increased fluid intake, etc. should be established. If the nasal membranes become too congested, the local application of hot steam towels to the face at intervals is very effective in obtaining relief.

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When colds and upper respiratory infections constantly recur, the general health of the patient must not be neglected. Excessive intake of carbohydrates seems to make one more susceptible to colds. Hygienic conditions should be thoroughly checked. Forced draft heating systems should be inspected as children playing on the floor are frequently subjected to blasts of dust filled hot air. Persons susceptible to colds should keep their bedroom windows closed at night and the heat turned off. The room should be aired daily.

A mother might tell you that her child has a profuse watery discharge from the nose, that it is worse at night, and that the nose becomes very stuffy and the child coughs most of the time it is in bed. Suspect an allergy and take away any fuzzy dolls or toys that may be in or near the bed. An antihistamine at bedtime will frequently alleviate these symptoms until a diagnosis is made.

There are many conditions which present persistent subacute, recurrent, or chronic rhinitis with constant swelling of the nasal membranes and a purulent or mucopurulent nasal discharge. Such conditions occur in simple mucopurulent rhinitis, sinusitis, nasopharyngeal infection with obstruction, and infection superimposed on an already present nasal allergy. All of these conditions may be present at the same time.

SINUSITIS

Severe sinusitis may be easily diagnosed by headache, pain and tenderness over the involved areas, mucopurulent drainage into the nasal vestibule, and often associated with an increased temperature, general malaise, etc. What can you do for an acute sinusitis? One of the best and simplest methods of relieving the pressure and therefore the headache, and to promote drainage is the local application of hot and cold compresses alternately to the face with equal intervals between the compresses. A sudden change from hot to cold is painful to the patient. I suggest the use of hot moist compresses for one half an hour, a half hour interval, and then cold moist compresses for the next half hour. This should be repeated constantly throughout the waking hours. I do not like "nose drops" because they cannot possibly reach all the nasal membranes and all the sinus ostia. A good fine spray is much more efficacious. I frankly do not believe it makes any difference

what nasal medication you use as long as the astringent is mild and the patient is not sensitive to any of the prescription's ingredients. The astringent may be combined with sulfa, penicillin, neomycin or any of the accepted combinations now available on the market. These preparations have some bacteriostatic as well as decongestive action. However, it has not been proven that an appreciable amount of any nose spray or nose drops enters the paranasal sinuses themselves. Therefore, they merely decongest the nasal membranes, promote better drainage from the sinus ostia and keep down nasal bacterial count. A prescription for intranasal medication should be isotonic, buffered, have a pH of 7.0 or less, and should not irritate the nasal membranes. There should be a minimum absorption of the effective constituents and minimum incidence of sensitivity reaction. It should not contain oil. If the preparation causes a "stinging or burning" sensation it should be discontinued. It is much wiser to use simple normal saline than to cause irritation of already inflamed nasal membranes.

There are several nasal medication preparations which I consider excellent. They are mild and cause no side reactions such as nervousness. They are good astringents, and are believed not to cause a rise of blood pressure. Examples are Vasoxy, Rhinalgan, Aramine Sulfate, and Neosynephrine. They may be used for children as well as for hypertensives.

The systemic use of chemotherapy and/or antibiotics should definitely be employed in all cases of sinusitis. I think it wise to abstain from using antibiotics as much as possible. I find the use of the triplesulfas, Gantrisin, Bio-sulfa and such preparations which have a wide bacterial spectrum, to be very effective. Penicillin alone does not produce as good results unless given in large continued doses. When these preparations are used, I strongly urge that they be given in sufficiently large dosage and for a period of at least four days. I have seen many cases of sinusitis flare-up because these drugs were used only for a day or two. If the patient's headache, pain, etc. persist in spite of the above treatment, he will unquestionably require mechanical drainage of the sinuses.

If you suspect that an allergy is present in conjunction with the sinusitis all of the above therapy should be used. The best intranasal medication in this case would be Drilitol or preferably Biomydrin. Antihistamines should also be administered. When

the sinusitis has subsided the allergy should be proven or disproven and treated, if found present. Allergy is frequently the underlying etiological factor in recurrent sinusitis, and a factor which should never be overlooked.

NASOPHARYNGITIS

Infection of the nasopharynx gives rise to more complications than involvement of any other part of the upper respiratory tract. It is one of the most difficult problems for the general practitioner to treat. Infection here can cause pain in the mastoid area by irritating the vidian and petrosal nerves. It can cause pain almost anywhere in the face by irritating the fifth nerve through the sphenopalatine ganglion, and also cause pain in the throat, coughing, and dysphasia by irritating the ninth cranial nerve. Most cases of chronic progressive deafness and otitis media, as well as persistent low grade fevers arise from involvement of this area. Infection of the nasopharynx and the pharyngeal walls associated with a postnasal discharge, is often the causative factor in prolonged unproductive cough and in recurrent or chronic bronchitis.

Chemotherapy and/or antibiotics should be given. Local treatment should be similar to that described under sinusitis. For cases which are not acute but are persistent, the local use of Furacin Nasal Solution Plain, Pickrell's Solution, or Chloresium Nasal Solution are excellent. If the condition continues to resist all therapy or complications arise, more definitive measures should be initiated. Cultures and sensitivity studies should be obtained in all cases of upper respiratory infections and their complications whenever possible, so that the proper antibiotic may be chosen at the onset of therapy.

Many cases of recurrent or chronic nasopharyngitis are due to excessive or infected lymphoid tissue in this region and will not subside until this tissue is removed or treated with radium. I have not experienced much success with roentgen ray treatment of this condition.

OTOLOGY

Infections of the external auditory canal are treated in a similar manner to skin infections. There are a multitude of preparations on the market today which are advertised as "sure cures" for external

otitis, but I find the Burrows Solution Pack is still very effective, supplemented with the local application of heat. This pack should be changed daily. If the infection is mycotic and not bacterial, a pack saturated with Cresatin and Thymol (five grains to the ounce) and changed daily, gives excellent results.

Before treating external otitis, be sure there is no otitis media associated with it. If both conditions are present it would be preferable to refer the case to an otologist. There are times when the swelling about the auricle is so pronounced and the periaural tissues are so tender, that it becomes difficult to differentiate between external otitis and mastoiditis.

Acute otitis media should be treated via three approaches—the external auditory canal, the nasopharynx, and the vascular system. Auralgan or Otodyne are good decongesters and pain arresters and are most effective when applied to the tympanic membrane at hourly intervals. A decongestent with or without other drugs should be used in the nose so as to reach the eustachian tube orifice. Chemotherapy or antibiotics should be employed systemically. If the tympanic membrane gives any evidence of fluid under pressure in the middle ear, a myringotomy should be done without delay. Frequently pain in, and even some slight tenderness over, the mastoid area may be noticed with acute otitis media. If the mastoid symptoms do not subside readily, then further consultation is in order.

After the pain and temperature in acute otitis media have subsided, the tympanic membrane should be observed frequently. It should return to its normal appearance in two or three weeks. If it remains dull or has any residual discoloration, an otologist should be consulted. He must then check for further pathology and instigate therapy. Failure to do this will frequently lead to early deafness, especially in children.

Quite frequently, especially in rural areas, a general practitioner has to perform a myringotomy. The following are a few suggestions which I feel will be of value when carrying out this procedure:

Be sure that the patient's head is held perfectly still or you may destroy a large portion of the tympanic membrane and/or cause trauma of the external auditory canal. The incision should be made in the posterior inferior segment and from below, upward. Do not make the incision from above, downward, or you may accidentally hook into an ossicle and

tear it loose. Be sure to make an incision and not just a stab. If the fluid which escapes from the middle ear is serous or serosanguineous, it is usually not necessary to use local medication. If it is purulent, Aureomycin Otic, Terramycin Otic, alcohol and peroxide, or one of the many preparations made for local use should be employed. If discharge from the middle ear does not cease within two weeks, more definitive treatment is indicated.

Recurrent otitis media, persistent slight diminution of hearing, and chronic otitis media, belong in the field of the otologist.

ACUTE LARYNGOTRACHEO-BRONCHITIS

This is a frightening condition for both the patient and the patient's family. It usually occurs at night and requires quick action on the part of the doctor. Allay the patient's anxiety by giving a sedative, but not enough to slow respiration. Spasm of the bronchial tube must be relieved. Loosen and help remove the thick mucous which is plugging the air passage. Adrenalin (1:1000) should be administered according to the age of the patient: large doses of antibiotics and chemotherapy should be given, and the patient placed in a warm steam tent. Often an emetic such as mustard will help the patient to cough out mucous plugs. The pulse should be recorded and stridor noted at least every 15 minutes. If the pulse increases 20 points in 15 to 30 minutes, or stridor increases, the patient should be hos-

pitalized immediately and oxygen made available in the ambulance.

EPISTAXIS

When summoned to the home of a patient with epistaxis, he will most likely be found lying on a bed and utilizing a weird assortment of house remedies. Dispense with them and instruct the patient to sit up. Place a two inch piece of cotton, which has been saturated with an astringent, into the bleeding nostril and have the patient lean slightly forward. Pinch the nostril firmly with your fingers for about ten minutes. Have him maintain an upright position so that blood will not drain back into the throat. Local pressure plus an astringent will usually check the bleeding.

If the bleeding does not stop, the nose should be packed. When inserting a pack, the first portion should be placed as high in the vault of the nose as possible. The last portion of the pack should be placed along the floor of the nostril. Hemo-Pak is a half inch wide strip of hemostatic, absorbable, cellulose gauze which is easily handled and does not have to be removed until it becomes very loose from absorption after several days. It is an excellent agent for nasal packing. Penicillin in large daily doses seems to help control the bleeding, especially when packing has to be removed.

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SYMPOSIUM

REGIONAL ENTERITIS¹

BURRILL B. CROHN, M.D.²

It is a great privilege to address you this evening. It is a pleasure to be in Baltimore,

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the home of so much medicine, and the originator of so many medical ideas in the past. It is sort of ironical for me to be here at the moment because our Mount Sinai Hospital in New York City has in the last few years transformed itself to a full-time institution, and has at the head of four of its major departments, Johns Hopkins men: Guttmacher, Hodes, Gutman, and Ravitch.

It would be interesting to take a moment to go over the historical background and progress of the last twenty or thirty years of my lifetime on the subject of these inflammatory diseases of the small intestines. In my early days ulcerative colitis was a rare disease; today it is well-known. I don't suppose you can enter any ward of the Mount Sinai without seeing several cases of ulcerative colitis. In 1932 with Ginzberg and Oppenheimer, we introduced the concept of regional or terminal ileitis, in which the distal segment of 8 to 12 inches of terminal ileum was involved in an inflammatory granulomatosis process.

About 1930, the medical world became conscious of another disease which had been previously described but to which little attention had been paid, that is non-specific segmental colitis. This process involved the proximal colon, cecum, ascending and transverse colon but did not involve the sigmoid; it was essential that the sigmoidoscopy be negative. This non-specific right sided or segmental colitis was a different disease in many respects from the so-called "universal" colitis with which we were familiar. About 1936, we began to be conscious of the fact that not only could you have a terminal ileitis but we recognized the concept of ileojejunitis, a process involving the whole of the ileum and part or all of the jejunum. To the picture of terminal ileitis or regional ileitis was now added the concept of ileo-jejunitis. Subsequently it was learned that combined forms of these diseases did exist: regional ileitis, terminal ileitis, segmental colitis, and universal colitis.

In the last two or three years there has been a still further advance of this concept because now we recognize involvement of the duodenum. This has been seen in at least nine cases and probable involvement of the stomach in two instances. Recently I saw one of my most outstanding cases of terminal ileitis with a skip area in the first portion of the duodenum and involvement of the stomach as confirmed by gastroscopy.

Regional ileitis is not an uncommon disease; the fact that my statistics run to about six hundred cases, means that this is not a rare disease, even though I am unfortunately relegated to the role of specialist in regional ileitis.

My experience with ulcerative colitis probably covers more than two thousand to twenty-five hundred cases: the proportion is roughly five to one, five cases of ulcerative colitis to one of regional ileitis. Segmental colitis is still less common, the proportion would be about one to twenty cases of universal colitis.

Regional ileitis is a clear cut concept; a disease of young people. The average age is about twenty-five to twenty-seven years of age. It affects young adults; males somewhat more than females. The youngest case I have seen was nine months of age, confirmed by an exploratory laparotomy. The oldest case I remember was seventy-one years of age, though recently in the office we encountered a case in the late sixties and were interested to note that this case of regional ileitis apparently had its onset in the later decades of life.

As to etiology, that is a difficult question which cannot now be answered. The etiology of the disease is not known. It acts like a bacterial disease, particularly with its suppurative complications. It is obviously not bacterial in origin because nowadays it is so simple to sterilize the intestinal tract within forty-eight hours with modern antibiotics. A sterile stool culture will be reported back within forty-eight hours after the initiation of strict and ample antibiotic therapy, but the course of the disease in regional ileitis is not changed. I don't know whether Dr. Machella will agree with me, but after you similarly sterilize the colon in the case of ulcerative colitis you have not to any great extent altered the course of the disease although you may have improved the gravity of the suppurative complications.

One may hypothecate that there is a virus which is responsible for this disease; when asked about mixed cases of ileitis and ulcerative colitis,

one may conceive of ulcerative colitis as caused by one virus, of regional ileitis as probably a different type of virus and of the mixed cases as being infections with both viruses.

Why a virus? Because otherwise I cannot understand how successful surgical cases which are operated upon will remain well for long years and then return with recurrences of the disease. The longest recurrence I have seen has been nineteen years which is almost as long as I have known regional ileitis. I can conceive only of a virus type of disease which will lie dormant after a supposed successful operation and then break down and recur so many years later.

Certain facts about the etiology of ileitis are important. The familial incidence of this disease is quite in contrast to that of ulcerative colitis. Once only in my lifetime have I seen ulcerative colitis in more than one member of the same family. Regional ileitis is not uncommon in more than one member of a family, thus father and daughter, aunt and niece, brothers and sisters; in fact, in the first case of regional ileitis I ever saw, the sister several years later was also proven to be affected with regional ileitis. Both cases are alive and well today following successful surgery. The familial incidence is positive in regional ileitis and is completely absent in ulcerative colitis.

The factor of trauma is interesting. One does not often see trauma initiate a case of ulcerative colitis, but you can see trauma initiate a case of regional ileitis. The automobile today is an important factor in the etiology of regional ileitis, in accidents the body being thrown violently against the steering wheel.

The clinical appearance of regional ileitis when it is clearly defined and well marked is so definite that there should be no reason to mistake the diagnosis. A patient with a history of low-grade diarrhea; with a slight temperature; with a slight or progressive anemia, and with abdominal pain, the suspicion of regional ileitis should be entertained.

The negative sigmoidoscopy and the negative barium enema will rule out ulcerative colitis. Any case of diarrhea with abdominal pain, pre-defecatory in nature is suspect. This sequence of events recalls the rule of Moynihan with duodenal ulcer, namely: pain, food, relief, pain, food, relief. In regional ileitis, or in the inflammatory diseases of the small intestines, the sequence of symptoms is abdominal pain, defecation, relief; pain, defecation, relief.

The diarrhea in ileitis can be very mild; it is important to remember that a small percentage (5%) of cases of ileitis may have constipation. It is very embarrassing to overlook a case of ileitis because the patient was constipated and never had diarrhea.

The intensity of diarrhea in inflammatory diseases is in relationship to the proximity of the diseased focus to the anal sphincter. The nearer the inflammatory focus is to the anal sphincter, the greater is the diarrhea. Cases of ulcerative colitis, where only the rectum is involved, watched over the course of years rarely progress beyond the rectum; they are characterized by ten to twenty stools a day, with urgency and spasm, and with the passage of mucus and blood. In right-sided segmental colitis with involvement only of the right side of the colon the diarrhea is materially less with an average of six to eight stools a day.

When the terminal ileum only is involved, there may be three to four stools a day with abdominal pain. When the jejunum itself is involved, the diarrhea is still more ameliorated and less severe.

A progressive loss of weight is important in regional ileitis; anemia also is significant.

In differentiating the functional from the organic diarrheas, it is important that the patient take his temperature at eight o'clock every night and record it. Sooner or later the case of ulcerative colitis or of regional ileitis will demonstrate a slight rise of temperature and if the evening temperature is accurately noted a slight

rise of fever will differentiate the functional from the organic diarrheas.

The estimation of hemoglobin in the blood is essential in all such cases; the neurotic diarrheas, the irritable bowel, the mucous colitis, the allergic diarrheas, do not progress to secondary anemia. But the case of regional ileitis will sooner or later develop a secondary anemia of rather mild severity.

The psychic manifestations of regional ileitis are important to remember. Some of our cases come to us from psychiatric institutions where the diarrhea has just been taken for granted and interpreted as a neurogenic or psychiatric manifestation. Many cases are seen which have been institutionalized in psychiatric institutions for nervous diarrhea in which the x-ray examination of the gastro-intestinal tract has been postponed or deferred so long that the correct diagnosis has been overlooked.

Sooner or later the patient with regional ileitis is liable to develop a mass in the right lower quadrant of the abdomen, but the mass may also be located in the midline or even in the left lower quadrant. Where the terminal ileum is long and where the sigmoid forms a large redundant loop, fistulization may take place between the ileum and the sigmoid, so that the mass is pulled by the sigmoid over to the left side of the abdomen.

The outstanding characteristic of the disease, the one which is pathognomonic and which demarcates it, is the formation of internal and external fistulae.

The terminal ileum is the seat of origin of such fistulae. The colon does not produce fistulae to other organs except perirectal or ischio-rectal abscesses and fistulae; a fact which is common to all inflammatory diseases of the large and small bowel. The functional diarrheas never produce fistulae. No matter how long-standing a diarrhea is, one can differentiate the organic inflammatory diarrheas from the functional diarrheas by the presence or absence of a perirectal abscess or a perirectal fistula. These

fistulae are characteristic of regional ileitis and do not occur in the functional nervous diarrheas or the diarrheas of ductless gland origin.

The terminal ileum represents to my mind a porous segment of the intestine. The ulceration, the granulomatous inflammation which originates in the submucosa, which goes on to invade the mucosa and causes secondary ulcerations, converts the terminal loop of ileum into a porous segment. The peptolytic enzymes of the intestinal content leak through the wall of the terminal ileum, follow the fascial planes and create fistulous tracks which travel far distances. These fistulous tracks may travel from terminal ileum to any other loop of small intestines; may travel from terminal ileum to large bowel, may follow the fascial planes and burrow and enter any hollow viscus. I have seen such fistulae perforate the body of the uterus. It is not unusual to see them perforate into the Fallopian tubes and give rise to salpingitis. They burrow into the urinary bladder, or into the posterior urethra in the male so that when the male urinates, he passes urine plus intestinal content and gas.

These fistulous tracks may burrow extensively and make their exit in the anterior abdominal wall in the scar of a previous abdominal incision, or even in the lumbar regions. They may terminate in the inguinal regions producing multiple fistulous tracks and openings in both of the inguinal regions.

The upper ileum rarely forms a fistula; the jejunum practically never originates a fistula.

Given the clinical picture of an abdominal mass plus diarrhea, an external fistula, fever, and secondary anemia, there is no excuse for not being able to make a clinical diagnosis or at least a provisional diagnosis of regional ileitis. Can the diagnosis always be made? Practically always, and either with or without radiographic confirmation. Some of the cases are so mild that they will continue for ten to twenty years with a mild diarrhea which is completely overlooked so that the diagnosis is not and cannot, be made.

Cases of acute regional ileitis are often violent with the onset of diarrhea and high fever, rigid belly and right lower quadrant abdominal tenderness; they simulate acute appendicitis. In between, you have all the variations from extreme severity of diarrhea and abdominal pain to the mildest type of manifestation in which the diagnosis can be overlooked for years.

I like to recall the case of a soldier who was in the Bataan death march, who undoubtedly had diarrhea when he entered the army, who survived the death march, survived concentration camp for many years and came in years later with a proven case of regional ileitis. In reviewing the history of diarrhea in his case it was almost positive that he had had regional ileitis during the entire period.

In another instance the patient had been a football player while in college, served through the war with the Marines, returned from service, and entered a professional football career; he had a most marked regional ileitis. I am sure that during that entire period he had regional ileitis. The markings in his intestines are so well defined and so sclerotic as to indicate an old and cicatrizing lesion.

Radiography is the final check on the diagnosis; when it is positive, it is conclusive. In about five per cent of the cases one can make a clinical diagnosis of regional ileitis, with negative radiographic findings. Often it has been my privilege to contradict the radiographer and to maintain the clinical diagnosis even though the radiographic films fail to demonstrate the disease. Fortunately in the largest percentage of cases radiographic confirmation is available.

The barium enema is the easiest way to pick up a lesion because in eighty per cent of the cases there is enough regurgitation through the ileo-cecal valve to demonstrate the terminal loops of ileum. Where it is not demonstrated by barium enema, a barium meal is indicated to study the small bowel. Radiography of the small intestine does not mean assigning the case to a technician and saying, take x-ray pictures on

the third, sixth, and ninth hours and show me the films tomorrow. So many cases of regional ileitis can be missed by arbitrary setting times for the taking of films, that in many of the hospitals where technicians are assigned a good part of the work, the diagnosis is often overlooked.

It is most important to take the x-ray films at the time when the terminal ileum fills. My old radiographer "cussed me out" many a time for spoiling his dinner and social engagements at night because he would sit with the case and sit with it till the terminal ileum filled. He would then take that final film which showed the disease; many of the cases which I see, have been passed up by radiographers because they haven't used the proper technique. At times the Miller-Abbott tube, or the Levine tube is passed down into the small intestine and barium is injected as a small intestinal enema. In recent years we have discontinued that practice to a large extent.

The inflammatory disease which we recognize as regional ileitis begins at the ileo-cecal valve (I'm more inclined to use the term "begin" than "ends"). Actually I think it begins just proximal to the ileo-cecal valve where there is a normal physiological stasis of the column of chyme or chyle as it approaches the valve; at that point of physiological delay we have practically almost all the diseases of the small intestine, such as ileo-cecal tuberculosis, and nearly all the benign tumors, Sarcoid, Hodgkins, lymphosarcoma, carcinoid, etc.

The disease is characterized by thickening and inflammation of the intestine; by a rigidity of the wall; by a destruction and elimination of the mucous membrane pattern in this area, and by a reduction of the lumen. When the lumen is filled with barium and an x-ray picture is taken, the "string sign" will be seen. "This string sign," which was described by Dr. John Kantor, is characteristic and almost pathognomonic for this type of disease.

The distribution of the lesion in the majority



FIG. 1. Regional ileitis—string sign

of cases is about twelve inches; ten, twelve or fifteen in most of the cases; eighteen, twenty-four inches is not at all unusual. Figure 1.

There are cases of regional ileitis particularly interesting to the surgeons because the manifestations so often begin with obstruction and in which only two, three or four inches of terminal ileum are involved. There also may be invasion all the way up; thirty-six inches, forty-eight inches, sixty inches or seven feet, which will carry you right up to the junction of the ileum with the jejunum.

Figure 2 is a characteristic picture of the "string sign" in the terminal ileum as demonstrated by regurgitation of a barium into the terminal ileum.

A diffuse ileojejunitis or an involvement higher up in the intestine makes it necessary to use the oral barium meal. With my experience in all the years I have been studying this disease, I have pulled a boner every once in a while by doing a barium enema, and forgetting to do a meal by mouth. It is rather humiliating to have your case return some time later with persistent

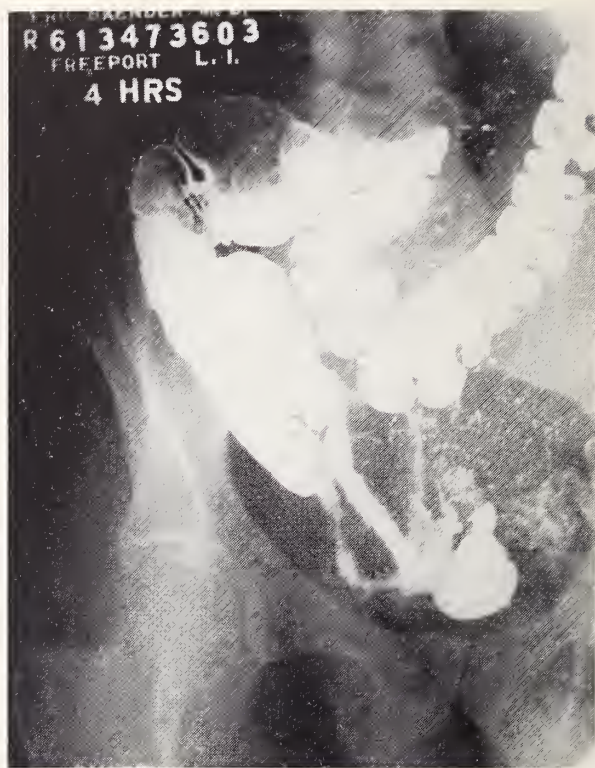


FIG. 2. "String sign" demonstrated by regurgitation of barium enema into the terminal ileum.

symptoms, and to suddenly become conscious of the fact that you forgot to do a barium meal.

There are some cases where the upper jejunum or the jejunum and ileum above are involved and the terminal ileum is not involved, and those cases you will miss unless you do a meal by mouth.

Figure 3 demonstrates the "string sign" with involvement of the entire ileum in a patient who had psychotherapy for eight years. This man came down from an institution where it had been taken for granted that he had a nervous diarrhea; the psychiatric manifestations were so predominant that the diarrhea was overlooked. You can imagine the astonishment of all of us when a routine G. I. x-ray series was taken to discover the involvement of the whole ileum.

A physician, who had been serving in a psychiatric institution in New York State for many years, had been joshed by his comrades because of his diarrhea. It never dawned upon any of

the doctors to take a gastro-intestinal x-ray in this psychiatric institution. He was the most surprised man to discover that he had regional ileitis.

Late in the disease one sees polypoid and cicatrical changes. I haven't said much about obstruction because obstruction is rare and takes place late in the course of the disease.

There is in addition to the cicatrizing, localized form of regional ileitis, a mucosal form, a rapidly spreading mucosal form which is very disturbing to us because it is the type of case that lends itself so badly to successful surgery. This type of case should interest the surgeons as well as the medical men because these are the cases that you like to leave alone.

The mucosal type of regional ileitis with rapid spread, is a very disastrous type to study. The clinical progress is fast and rapid, the downward course is extreme. When we talk about surgical treatment, you will see that in recent years this type of case has warned us away and made us restrict ourselves to sclerosing cicatrical types where the upper end of the lesion can be well defined.

Perirectal fistulae usually occur as complications of infection of the crypts of Morgagni. The infection—if it be an infection—is brought down with the fecal column, rests in the rectum and infects the crypts, giving rise to an ischio-rectal abscess or ruptures internally to the rectum and externally to the buttocks giving rise to a perirectal fistula. There are some cases in which the fistulization begins above in the ileum; in which lipiodol injection of the fistulous tract will allow you to follow this fistula all the way up from the rectum right to its base in the terminal ileum.

These fistulas are very interesting, since, if you short-circuit the lesion or resect the lesion, the fistula dries up.

Recto-vaginal fistula is another characteristic of this disease, though not necessarily pathognomonic for regional ileitis because it can occur and



FIG. 3. Involvement of the entire ileum in a patient treated from the psychiatric viewpoint for eight years.

does occur with ulcerative colitis, and as a common complication to pregnancy and delivery in cases of ulcerative colitis. If you insert your finger into the rectum in ulcerative colitis and bend your finger forward, you will find the oldest ulceration in the rectum. It is that anterior ulceration which breaks through the septum between the vagina and the rectum and gives rise to the recto-vaginal fistula. These fistulae are most difficult to cure by surgical means.

Ileitis and ileojejunitis are characterized by low-grade temperature. Figure 4. The general internist must bear in mind that low-grade temperature with joint involvement and with eye manifestations is characteristic of both ulcerative colitis and of ileitis.

The joint involvement and eye manifestations are more common to ulcerative colitis than they are to ileitis; such low-grade temperature is often mistaken for rheumatic fever or periarteritis nodosa, or lupus erythematosus disseminatus, or any of the diseases which are

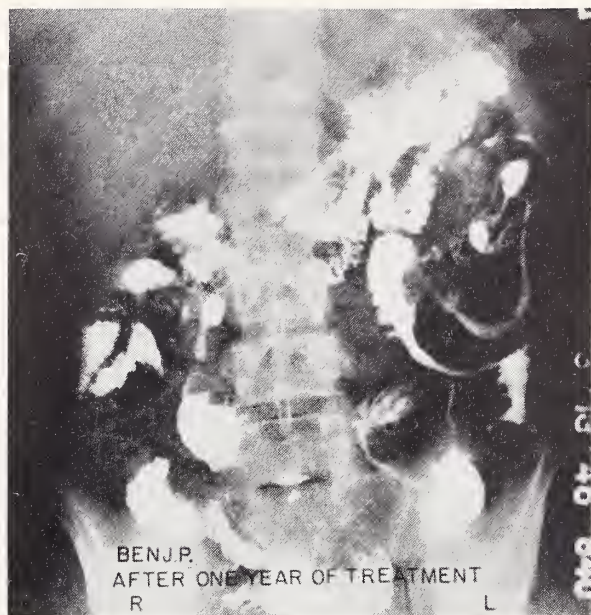


FIG. 4. Ileitis and ileo-jejunitis

accompanied by low-grade temperature and low leukocyte counts.

Any low-grade temperature with low leukocyte count, with continuous fever of unknown origin should always be suspected of possibly being due to regional ileitis or a right-sided or a segmental colitis. I have been in this city twice to see cases of this type. One was explored at Johns Hopkins by Dr. Firor, some years ago, but nothing surgically could be accomplished because of the widespread extent of the disease. The other was a case which had continuous fever with joint manifestations and in which the discovery of perirectal fistula cleared up the diagnosis.

Incidentally, one rarely sees a death in regional ileitis; one practically never sees an autopsy. The acute fulminating regional ileitis cases are best left alone. If anybody is brash enough to operate upon them and attempt a resection a high mortality rate is invited.

The terminal ileum rarely heals itself. The upper ileum and jejunum are capable of self-healing in a large percentage of the cases. This constitutes an important therapeutic difference because terminal ileitis if not able to heal itself is amenable to surgical treatment, while the

upper small intestine which is not amenable to surgical treatment has the capacity and the faculty of healing itself under favorable conditions.

With the involvement of the upper ileum and jejunum, nutritional changes occur which remind one a great deal of sprue. The two diseases cannot be confused in any respect. It should not be difficult to differentiate sprue from ileo-jejunitis, because the roentgenographic picture of sprue is so definite. The radiographic picture of ileo-jejunitis is also characteristic. Both diseases are characterized by enlargement of the spleen, by a primary type of anemia, by clubbing of the fingers and by nutritional disturbances due to impaired absorption of electrolytes and nutriment. So-much-so that in diffuse ileo-jejunitis, one often sees a hyperchromic type of anemia; one also sees tetany, salt-deprivation, and potassium changes that are really clinically significant. Nutritional disturbances and loss of weight are most characteristic of diffuse ileo-jejunitis.

I don't think that the present-day surgeon would attempt the sort of surgery which was undertaken in the early days before we learned that the upper jejunum is capable of healing itself.

We are now beginning to be conscious of the fact that there is a type of pure jejunitis with involvement only of the upper jejunum, as described in Germany. We have seen few of these cases; we have many records of localized resections of the upper jejunum; and are beginning to be more cognizant of this type of the disease, as we also recognize involvement of the duodenum. The Mayo group published five cases with involvement of the duodenum some years ago. Our staff at the hospital are about to report five more cases with involvement of the fourth portion and the third portion of the duodenum. Usually there is obstruction, with vomiting. The picture of post-pyloric obstruction is very characteristic of ileo-jejunitis with involvement of the duodenum. The operative cure of such a

complication is very difficult to undertake. It can only be accomplished by anastomosis or some form of gastroduodenostomy or duodeno-jejuno-stomy with transection of the duodenum if it is possible above the lesion.

I believe that I have seen stomach involvement in three cases. A recent publication from England, cited two proven cases of ileojejunitis involving the stomach. This morning, I saw the gastroscopy for the second time on a case of ileojejunitis or ileitis with involvement of the stomach.

There are mixed forms of ileitis and colitis. I am sure Dr. Machella will take up this topic. Dr. Machella will probably describe to you the seriousness of ulcerative colitis which is a much more severe and serious disease than ileitis or ileojejunitis; when one meets the combination of ileitis with ulcerative colitis, two of the most serious diseases are then combined and superimposed one upon the other.

In the few minutes which I have left, I'd like to talk about the therapy of regional ileitis. As far as the differential diagnosis is concerned, there are other diseases that affect the terminal ileum which must be differentiated from regional ileitis.

I have been very confounded by lymphosarcoma of the terminal ileum which may be diagnosed mistakenly as terminal ileitis. The clinical picture may be typical of ileitis without fistulization, but characterized with a progressive downhill course and "string-sign" in the radiographic films.

Carcinoid of the terminal ileum can produce the clinical picture and the radiographic "string signs" of terminal ileitis so much so that differentiation is impossible without resection. Abdominal Hodgkin's disease with multicentric involvement of the lymph tissue throughout the intestinal tract can give a clinical picture very much like regional ileitis; very confusing; the clinical course is, however, much more severe and more rapidly fatal.

Endometriosis with implantation upon the

terminal ileum confused me once and led me to a diagnosis of regional ileitis in a woman of which the diagnosis was finally clarified. But in general all of these diseases are extremely rare. They are our fanciful rarities in medicine; regional ileitis is the common disease.

Is there a medical treatment for regional ileitis and what is the prognosis? In my three hundred odd cases which I followed up and published in 1947, I think I quoted about twelve cases of spontaneous cures. If these twelve cases had been followed longer, I'm not sure they would have remained cured, or whether they would not have broken down with recurrences after a length of time.

The medical treatment of regional ileitis today rests upon supportive low roughage diet; nutrition is very essential. The blood proteins must be studied, the albumin globulin ratio must be noted; the calcium content and sodium content of the blood must be seen. Transfusions are essential. Vitamin replacement is important. The use of the newer antibiotics is recommended if not for the disease at least for its complications. Sulphathaladin is used almost to the exclusion of all the other sulpha drugs. I have tried azopyrin, sulfasuxidine, and some of the newer sulpha drugs, but the most effective to my mind is sulphathaladin which can be prescribed over weeks and months without worrying about agranulocytosis or hepatitis, because of the lack of absorption of these insoluble sulfa derivatives.

Of the other antibiotics, penicillin is useless in the intestinal tract for any of these inflammatory diseases except perforation with peritonitis. I have yet to prescribe my first capsule of aureomycin or terramycin because I know that both aureomycin and terramycin are capable in themselves of producing diarrhea with changes in the intestinal flora with overgrowth of monilia or staphylococcus aureus. These are capable of giving rise to a new type of diarrhea which may be almost as severe as the original disease. My old standbys are streptomycin and

chloromycetin; chloromycetin is one of the most powerful and successful of intestinal antibiotics in spite of the fact that agranulocytosis may occasionally be produced.

The interest, of course, to date centers upon two other aspects of therapy. Is this a psychosomatic disease? and the use of ACTH and Cortisone. In my opinion ileitis is not a psychosomatic disease. If I am pinned down for a definite answer, yes or no, I would say that ulcerative colitis is definitely a psychosomatic disease subject to every psychic influence. I am now convinced that psychic trauma can originate ulcerative colitis a fact which I wouldn't have conceded a couple of years ago. As for the course of ulcerative colitis, the psychic factors are important throughout and the cure of the patient depends to a large extent on the rapport of the physician with the patient and his treatment of the psychic state of mind.

But in regional ileitis the psychic factors are relatively unimportant. ACTH and Cortisone are currently used in the treatment of regional ileitis and ileojejunitis, because in ileitis and ileojejunitis just as with ulcerative colitis, the beneficial effects are so immediate and so prompt, the improvement of the appetite, the euphoria, the general well-being are so important that the patient is much benefitted by ACTH which can then be followed by Cortisone or hydrocortone by mouth.

A recent patient had been taking twenty-five milligrams of Cortisone uninterruptedly for a year without bad effects. As far as the dosage

of the ACTH is concerned, as I travel over the country I am more and more amazed at dosages. I find myself extremely timid in my dosage and possibly very insufficient in recommending adequate dosage.

Some institutions have been using up to a hundred to two hundred milligrams of ACTH intramuscularly for the treatment of ileojejunitis, with benefit; as in sprue hydrocortone seems more efficient than Cortisone when given by mouth.

Surgically, we still tend to short-circuiting rather than resections. We deplore the fact that we have twenty-five per cent or more of recurrences which recurrences can occur as late as nineteen years, after the original operation. Surgery is adaptable to terminal ileitis, particularly when it is in the cicatrized or rigid sclerotic segment with an upper limit which can be well defined at the operating table. Even with twenty-five per cent of recurrences, surgery is well indicated as a cure for regional ileitis particularly in the presence of fistulous complications, the appearance of an abdominal mass, or the presence of obstruction.

Recurrences proximal to the site of intestinal anastomosis are best managed in a conservative manner. Reoperation and further short-circuitive procedures may lead to higher recurrences until both much of the utilizable small intestine and its function in maintaining nutritive balance have been sacrificed.

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CHRONIC IDIOPATHIC ULCERATIVE COLITIS

Problems in Etiology and Management

THOMAS E. MACHELLA, M.D.*

ETIOLOGY

Among the major hypotheses advanced to account for the development of ulcerative colitis are; infection, deficiency of a specific intestinal factor, excessive lysozyme production, damage to the colon by proteolytic enzymes of the upper gastro-intestinal tract, allergy, and emotional factors.

1. *Infection?*

The clinical picture of ulcerative colitis so frequently characterized by diarrhea and fever as well as the pathological appearance of the colon have strongly suggested an infectious etiology. It was natural, therefore, that attempts be made to isolate a specific organism, and indeed a variety of bacterial as well as other organisms had been incriminated.

The two which have stimulated the greatest amount of interest have been: The dysentery organisms and the gram positive diplococcus. I won't go into the evidence suggesting that these organisms are important in the etiology, but I will give you some of the points against the contention that the disease is caused by either of the two organisms.

As far as the dysentery organisms are concerned, there has been a failure to isolate dysentery organisms in large series of cases by several different groups of workers. Furthermore, there is a lack of infectiousness of the disease. It is rare to find more than one case of ulcerative colitis in the family and it is still more rare to find more than one case occurring in the family simultaneously. Finally, the finding of only one case of ulcerative colitis in a sixteen year fol-

low-up of 102 cases of bacillary dysentery by Brown and Bargaen speaks for itself.

As far as the evidence against the diplococcus is concerned, it consists mainly in the fact that it has been possible to isolate the organism from the feces of patients with a variety of intestinal diseases and this has led to the conclusion that the organism is a secondary invader.

The evidence against ulcerative colitis being due to a specific bacterial agent at all is as follows: 1) There has been a failure to isolate a pathogenic organism uniformly and, 2) the percentage of patients who improve while anti-bacterial agents are administered is about the same as from some measures not aimed primarily at treating infection. A summary of the reported results of various sulfonamides reveals that improvement was attributed to them in 57.7% of 1,275 cases. A similar survey of the results ascribed to antibiotics reveals improvement in 61.6 per cent of 167 cases. There have been far fewer reports on the results of treatment with antibiotics than with sulfonamides.

My own experience with these agents has been disappointing. The disease has its variations in severity and duration, and when I have used these compounds in really stubborn cases, no detectable favorable effect on the clinical course of the disease has been produced. For example, sulfasuxidine, penicillin, and streptomycin have been administered at different times to a specific patient with no effect on the diarrhea or on the fever over a period of some 40 days. Finally, the patient was given large doses of aspirin because he had joint manifestations, and everything quieted down very nicely. On the other hand, another patient was brought to the hospital with fever and diarrhea. She received no treatment whatsoever except reassurance and the security

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of the hospital. Her temperature and diarrhea subsided very nicely. It could be very easily said that if extract of watermelon seed, or a sulfonamide, or whatnot, were administered at that time, that agent might have been credited with causing a subsidence of symptoms.

Problem of Depression of Bacterial Flora of Colon. The role of bacterial flora of the colon in the maintenance and accentuation of the disease is very difficult to assess. This much can be said:

1) There is a lack of correlation between changes in the fecal flora brought about by the various antibacterial agents and the clinical course of the disease.

2) Careful studies by Marshall and his associates, at the University of Chicago, have revealed that although the fecal flora can be altered temporarily by the sulfonamides, after a while, the flora resembles that of the untreated patient in type and quantity.

3) A fecal flora resistant to antibiotics develops more or less rapidly after continued administration of the compounds.

4) The use of these agents may be deleterious. Side-effects including diarrhea and fever, on the basis of ulcerations in the colon not previously present, can result from their use. I have seen such occur and it has been reported in the literature. I, personally, do not use antibiotics or chemotherapeutic agents in ulcerative colitis unless suppurative complications threaten or exist.

2. *Ulcerative Colitis—a Deficiency Disease?*

The possibility that ulcerative colitis may be a deficiency disease and that the responsible factor is lacking from the intestinal tract was proposed by Gill in 1945 on the basis of favorable results obtained when preparations of hogs intestinal tract were administered.

The results of therapy with various preparations of various portions of the hogs intestinal tract have, in general, been disappointing. Good results have been reported in anywhere from 52 to 81 per cent of 104 cases, depending on the criteria used in judging effectiveness of treat-

ment. My own experience with a preparation of hog's duodenum in a small number of intractable cases has been unsatisfactory. In fact the preparation appeared to cause a great deal of flatulence and some of the patients refused to continue taking it.

3. *Ulcerative Colitis Due to Excess Lysozyme Production?*

The finding of an increased concentration of lysozyme in the stools of patients with ulcerative colitis, led Meyer and his associates to suggest that lysozyme is of etiologic importance in the disease. There can be little doubt that an increased amount of lysozyme is found in the stools of ulcerative colitis patients during activity of the disease. This finding has been confirmed in more than one laboratory.

It was postulated that lysozyme removed the protective surface mucus from the colon by virtue of its mucolytic activity and this favored ulceration of the denuded mucosa by indigenous bacterial flora.

The evidence against the lysozyme hypothesis is as follows:

1) The original work on animals whereby ulcerations were produced by the instillation of lysozyme into the colon of dogs has not been confirmed.

2) It has been found that lysozyme in large amounts is present in granulation tissue and that pus cells and bacteria can produce lysozyme.

3) An inability of some workers, such as Glass and his associates, to demonstrate any mucolytic activity of lysozyme in vitro on colonic mucus.

4) There has been a lack of correlation between fecal lysozyme titres and the clinical course of the disease when antilysozyme agents were effective in depressing fecal lysozyme titres.

5) There also has been a lack of a spectacular benefit from the administration of antilysozyme agents. Good results have been reported in 66.1 per cent of 121 cases treated with various antilysozyme agents.

4. *Ulcerative Colitis and Pancreatic Enzymes*

Dr. Portis suggested that pancreatic enzymes might be of importance in the etiology of ulcerative colitis. He based his concept on the basis of damage to the colonic mucosa of dogs following the instillation of 2 per cent trypsin.

The evidence against this hypothesis is as follows:

1) The occurrence of ulcerative colitis in individuals with a proven deficiency of the external secretion of the pancreas as a result of chronic pancreatic disease.

2) The recurrence of activity in the colon following ileostomy, i.e., even though the small intestinal content is diverted from the colon and pancreatic enzymes have no chance to get into the colon.

5. *Allergy*

The etiologic role of allergy in ulcerative colitis was proposed by Dr. Andresen and stressed by Dr. Rowe. The reason for their concept has been that they obtained favorable results when food allergy was taken into consideration in the management of the disease. Dr. Andresen, for example, felt that allergy was responsible in 66% of his cases, while Dr. Bassler thought that allergy was significant in about twenty per cent of his. Drs. Collins and Pritchett, after careful study of their cases, failed to find that food allergy was a common cause of the disease, but found that allergic management was helpful.

To me the situation in regards to allergy seems to be as follows: 1) Food allergy has not been established as a cause of ulcerative colitis and, 2) food allergy should be looked for in every case of ulcerative colitis and when present, should be taken into consideration in the management of the patient.

6. *Role of Emotional Factors*

The role of the psyche in the etiology of ulcerative colitis was emphasized as far back as 1930 by Dr. Murray, but not much attention was

paid to this aspect of the disease until recently. The reason for this has been, not only the influence of those who believed in a bacterial etiology, but the enthusiasm aroused by the first reports of each of the chemotherapeutic agents, as they were discovered. However, as the early enthusiasm attending the use of these agents was replaced by disappointment, increasing attention has been paid to the role of emotional factors.

Characteristic personality traits in the patients have been uncovered as well as evidence of unsatisfactory relationships between the patient and one of the parents. Impressive relationships between emotional stress and the onset of the disease and the occurrence of relapses, have been uncovered by individuals who take enough time to look for them. Furthermore, the results of psychotherapy, skillfully administered, have been better than from many other regimens. The results of psychotherapy, poorly administered, as one would expect, have been unsatisfactory and at times harmful. Many of the patients can be handled by the internist acting as his own psychiatrist, particularly if his personality is such that he can instill confidence and arouse hope in a patient who has been subjected to a variety of emotional frustrations and insults. Occasionally, expert aid from a trained psychiatrist may be necessary.

A summation of the results of miscellaneous therapy reveals a tremendous variety of therapeutic measures employed, each with satisfaction to its advocate. Adrenal cortical extract, arsenic, benadryl, chlorophyll, intragastric drip, medical ileostomy, propylthiouracil, testosterone, vagotomy, vitamin B₁₂, etc. The results from each are claimed to be good. How can good results from such a wide variety of therapeutic regimens be explained? To me, it simply indicates that the disease responded to the psychotherapeutic value of the program used. After all, the simplest form of psychotherapy is reassurance and such reassurance is supplied the ulcerative colitis

patient when he sees any doctor who makes a good impression on him and in whom the patient has faith and confidence. If at the same time, a new remedy is prescribed in a convincing manner, the chances are two or three to one that the symptoms will remit temporarily. Such a situation, I feel certain, accounts for the 60 to 70 per cent, or even higher, of the good results from most of the regimens used.

Analysis of records will reveal cases in which correction of patient's problems resulted in remissions which have lasted up to 8 and 9 years.

For example a patient with symptoms while under considerable stress as a result of his wife's dying of carcinomatosis had a disappearance of symptoms after her death. The patient remarried and has been in complete remission for nine years.

Another patient's emotional problem revolved around a desire not to have further pregnancies. Barium enema revealed a badly diseased colon. With the full cooperation of her husband, the fear of future pregnancies was removed and she lost her symptoms. Thirty-two months later, still asymptomatic, the colon looked as if it had never been diseased to the extent indicated earlier. She has been in remission for eight years and has survived a cholecystectomy and a myocardial infarction without a relapse in symptoms of ulcerative colitis.

A rather badly "chewed-up" colon was revealed by barium enema in a little boy, aged thirteen, who had a problem. He weighed forty-eight pounds, had bed sores and contractures of the knees, and was desperately ill. He had involvement of not only his colon but also of his small intestine. Surgery was considered but was turned down by the surgeon because of the critical condition of the patient and the extent of involvement of the small intestine. We tumbled on to what his problem was, and handled it to his satisfaction. It was resolved by prescribing psychiatric treatment for the boy's mother. He began to improve and went into complete

remission in which he has remained for the last 8 years. At present he weighs some 180 lbs. He has been in remission eight years, and his colon appears entirely normal on barium enema examination.

A 41 year old housewife and mother of 3 children, came to see me while on her way to another city to see a doctor who was supposed to be having success with a new antibiotic. She had had a trial of the older ones without benefit. I told her that I didn't think antibiotics would supply the solution of her problem, and that I thought that she was very unhappy about something. She broke out into tears and admitted that she was very, very unhappy. She also stated that diet was not important because when she was on vacation with her husband she ate anything she wished, including cabbage, and felt well. However, when she returned home, took antibiotics and adhered to a low residue diet, the colitis became active again.

Well, this was exactly what I was looking for. I learned that her husband, an ambitious attorney, wasn't spending very much time at home. He was a good man, had built her a large new home, but had to work hard to enlarge his law practice so that he could pay off the mortgage. The patient's mother and father, who lived with them, criticized him constantly for being away so much; this didn't help. She felt that these factors were responsible for her unhappiness. I agreed and suggested that her mother and father move into other quarters. She thought this could be accomplished readily. I also said I wanted to talk to her husband. I felt I would be able to get him to see that he could pay for the new home much earlier if he spent more time in it and didn't have to pay for expensive antibiotics, transfusions, hospitalizations, etc. which her illness during the past 7 years had necessitated. She brought him along on the next visit and I told him the facts as I saw them. He replied "if you think that I'm doing this to my wife, it stops as of now; tomorrow we leave on vacation" and they did. The

parents moved into an apartment nearby. She has had no symptoms of ulcerative colitis since that time, some 4 years ago. It took only two hours to discover the trouble and correct it. Not all of my cases of ulcerative colitis are as easily managed as this one was.

ACTH AND CORTISONE

Factors underlying the basis for the use of ACTH or cortisone in the treatment of ulcerative colitis have been the occasional occurrence of erythema nodosum and arthritis as complications, as well as the finding of low values for urinary ketosteroid excretion.

Cortisone therapy may produce a rapid subsidence of fever, a gain in weight with a return of appetite and a restoration of the erythrocyte sedimentation rate to normal. Diarrhea ceases promptly or subsides gradually. Erythema nodosum and arthritis rapidly disappear. Roentgen and sigmoidoscopic evidence of healing lags behind clinical improvement and is seen only if the remission induced lasts a long time.

The type of patients who appear to respond best to ACTH or cortisone are: 1) those with the acute fulminating disease, 2) badly debilitated individuals, 3) those whose total circulating eosinophiles are low and, 4) those with erythema nodosum and arthritis.

These agents do not cure the disease any more than insulin cures diabetes. Emotional factors should be searched for and handled after the patient begins improving. The dosage should be gradually reduced to maintenance levels and then further reduction made slowly (at weekly intervals) until none is being administered in order to give the adrenals a chance to become restored. This should be done to avoid a dependence on the compound, which in the case of cortisone can be almost as bad as addiction. When tapering off the dosage of cortisone it is sometimes well to administer ACTH concurrently. When using these agents one must keep in mind that infection may be masked; because, they in addition to having an antipyretic action,

lessen toxemia, and thus remove valuable signs of serious infection.

It has been suggested by several individuals that perforation of the colon occurs more frequently in those ulcerative colitis patients who are on these compounds. I don't see how the point can be proven. Ulcerative colitis is a disease in which perforation is a well recognized complication. How is one going to tell whether or not cortisone or ACTH administration increases the susceptibility to perforation except by comparing large series of cases. If perforation never or rarely occurred in ulcerative colitis and then occurred frequently after cortisone was administered, I'd be willing to attribute the increased incidence to cortisone. I have gone over our own cases. In about 100 patients who did not have cortisone, there were 7 who perforated; in 20 treated with cortisone, one perforated. I have recently learned from a colleague who just returned from England of a series of 100 cases treated with hormones and another comparable number treated by other measures. There were 3 or 4 perforations in the group who did not receive the hormones as against none in the group that did.

A patient with evidence of extensive involvement of the colon on barium enema as well as the small intestine, had at least five perforations in the colon as indicated by the escape of barium outside the confines of the colon. The surgeons were inclined not to operate on the patient because they felt she was in too critical a condition. The patient was placed on cortisone and made an excellent recovery. She now attends our clinic as an out-patient. She has gained considerable weight and can do her own house work. As a matter of fact, she has succeeded in marrying off her divorced daughter quite happily and I predict no recurrence unless the daughter's second marriage is unsuccessful.

Our policy, as far as these compounds is concerned, is not to use them unless nothing else works and the situation is desperate. We have used them in cases with perforation, mas-

sive bleeding and with massive edema as a measure of desperation with very satisfactory results.

CARCINOMA AND ULCERATIVE COLITIS

The problem of carcinoma and ulcerative colitis is a serious one because if the disease predisposes to an alarmingly high incidence of colonic malignancy, then perhaps prolonged efforts at medical management in certain instances should be avoided and the colon removed. The literature up to 1944 was reviewed by Lynn. He found that the incidence of colonic carcinoma was 1.9 per cent of 1,467 cases. I have reviewed the literature since 1944, and have found the incidence of cancer is 3 per cent in 6,890 patients. These figures have not been corrected for the natural incidence of carcinoma of the colon and rectum which ranks fairly high as a cause of death in adults.

A 3 per cent incidence of carcinoma of the colon in ulcerative colitis must, of course, be taken into consideration in the management of patients with the disease, but it should not provide an occasion for hysteria on the part of the physician. Such an incidence is less than the mortality of colectomy in several clinics. What is more impressive than the incidence of carcinoma in ulcerative colitis, is the age of ulcerative colitis patients who get carcinoma. In Dr. Sloan's 2000 cases at the Mayo Clinic, the incidence of cancer of the colon was 5.4 per cent. The mean age was forty-two years. The greatest number occurred between the ages of thirty and thirty-nine years. The youngest was fifteen at the time of death.

Opinions of many are in agreement on some of the points in the problem. In the first place, most individuals agree that carcinoma appears to develop more readily in the colons of those who have had the disease a long time. Secondly, the carcinoma which develops is highly malignant and metastasizes early and thirdly, it may develop in more than one site. Most writers on the subject are not impressed with the tendency of pseudopolyps to undergo malignant change.

I, personally, am considerably scared of pseudopolypoidosis, particularly in the patient who continues to have low-grade activity of his colitis. I do not hesitate to recommend colectomy in such cases. I am less afraid in the patient who is doing very well and is in remission. I have seen roentgen evidence of pseudopolypoidosis disappear in such cases.

SURGERY FOR THE INTRACTABLE CASE

Surgical intervention in the patient with intractable symptoms is an individual problem and each case should be decided on its own merits. The surgeons complain, and frequently with justification, that medical men permit patients to go down hill too far before they ask for help. They, therefore, operate on bad risks, and have a high mortality. On the other hand, there is no doubt in my mind that some patients have been committed to an ileostomy life unnecessarily, because remissions can and do occur even after months of treatment in apparently hopeless situations. My own policy is to recommend surgery when the emotional problems motivating the disease cannot be handled and the outlook is hopeless.

As you all know, a small intestinal involvement may occur in association with ulcerative colitis. An ileostomy performed through diseased ileum predisposes to fistula formation, abscess, and these mean a prolonged convalescence. The small gut should be X-rayed in every patient with ulcerative colitis as soon as practical and again before surgery, if a long interval has elapsed between the initial small intestinal X-ray and time of surgery. Involvement of the small gut may be more evident in the subsequent examination and be so extensive as to contraindicate surgery, in which case one may have to resort to cortisone or ACTH.

In summary, problems of etiology and management have been discussed. It is important that treatment should be individualized. Supportive therapy consists of the correction of existing deficiencies; i.e., transfusions and iron for anemia, prompt correction of electrolyte

imbalance including potassium deficiency, and dehydration, and the administration of vitamins and a nutritious diet rich in protein. Emotional problems should be tactfully searched for and solved. This requires, very frequently, time and patience on the part of the physician. ACTH and cortisone may prove to be life saving in cases that defy ordinary conservative measures.

The use of these agents should be discontinued after the dosage has been gradually reduced over a period of weeks or months. Surgery should be resorted to in those cases in which a remission can't be induced by other means.

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QUESTION AND ANSWER PERIOD

DR. GUNDRY: I want to thank Dr. Crohn and Dr. Machella for their most interesting presentation. Their talks are open for discussion or for questions from the floor. Does anyone want to comment or ask questions?

Q. DR. HOWARD: I'd like to ask Dr. Crohn if he feels that one operation for terminal ileitis is all the patient should have? It has been my feeling that if one has an operation for terminal ileitis and has a recurrence two or three years later, that I'd like him to have a second crack at a cure because if he doesn't have that second crack, he probably would be inclemented by it for the rest of his days.

DR. CROHN: I must agree with Dr. Howard on that question to a certain point. The reoperation of all the cases of terminal ileitis as soon as they recur led to more recurrence and to more operations. So that in the olden days we saw occasionally two or three ileotransversecolostomies ending up with ileo-sigmoidostomies, and many of those cases turned out to be so disappointing that the more conservative plan has been accepted.

I would prefer nowadays to handle my patients as a medical problem rather than a surgical one. If perforation or fistulas occur or the patient develops fever and loss of electrolytes and nutrition, I am perfectly willing to take a second try, but my attitude is much more conservative today than it was.

Q. I'd like to ask the discussants if in their

opinion in most cases of acute ileitis, ulcerative colitis, cure themselves or are there any statistics to show for instance what happens to a large series of medically treated ulcerative colitis patients over a long period of years. What happens to them at the end of ten or twenty years?

DR. MACHELLA: There is a feeling in the minds of some clinicians concerning acute ulcerative colitis, or the so-called fulminating form, that once it subsides the chances of it recurring are small. My own answer to this question is that there isn't any difference between the acute or the chronic form as far as prognosis is concerned; that both depend on emotional factors, and if you handle the emotional factors or they are handled for you, the disease will subside whether it is chronic or acute. If the patient had acute ulcerative colitis and the motivating emotional factors persist or recur, then a relapse is very apt to occur.

The longest period of remission that I have seen has been about twenty-five years. This particular patient developed acute ulcerative colitis when all her relatives were killed in Russia during the revolution in the short period of two or three weeks. She was very sick and was transferred to the surgical side of our hospital for an ileostomy. When she found out what was going to be done, she signed a release, went home, improved, and has had no ulcerative colitis since. She was recently readmitted (25 years later) with Hodgkins disease.



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Q. Does vagotomy have any role in the therapy of regional enteritis?

DR. CROHN: Twice I have seen vagotomy used for a diffuse regional ileojejunitis; the results were sad. I only wish, Mr. Chairman, I could develop as much enthusiasm for psychotherapy as Dr. Machella. He makes it very simple. First of all, I'd like to ask Dr. Machella how often, and whether he has seen some of the very disastrous and sad results of attempts to treat with psychotherapy, patients running 104 temperature and so toxic that they can't eat. My experiences with that type of attempted psychotherapy in the critical period, has not been good. I'm very glad Dr. Machella gives the impression that he is his own psychotherapist which I think is the important role that all of us have to play when we treat cases of ulcerative colitis or regional ileitis. Remember, you've got to be around the individual and you have to know a great deal of life; you have to understand child psychology, and be able to understand the problems of the individual. It is not as simple in practice as Dr. Machella makes it.

On the subject of carcinoma—I know that Dr. Machella has seen the recent literature, for the incidence of carcinoma in ulcerative colitis with figures of controlled incidence of carcinoma in the general population. I am pretty well convinced the incidence of carcinoma of the colon is higher in ulcerative colitis than it is in the native population as a control. Also that most of these carcinomas take place in the rectum. Also that they occur after twelve or more years of prolonged ulcerative colitis. Also the fact their most significant factor is early metastasis to distal organs. In the series of thirteen cases seen by Dr. John H. Garlock only one case has survived after ten years.

DR. MACHELLA: The difficulty with psychotherapy is that it is time-consuming. One has to drop whatever he is doing when the patient is in trouble and help him out. Unless one is willing to do that, one might as well not try it. Actually,

it takes patience, common sense, a sympathetic attitude, and, above all, a lot of time.

I agree that it would be foolhardy to turn a patient who is sick with a fulminating colitis over to a psychiatrist. Such a patient shouldn't even have a barium enema or proctoscopy.

I have seen cases turned over to psychiatrists not familiar with the disease. I know of at least two patients who committed suicide after the first interview. A third patient, a young man who after the first hour with a psychiatrist, returned to his hospital room, put on his street clothes, and disappeared. He has not been seen or heard of since.

I have referred patients to the psychiatrist when I felt I wasn't getting anywhere; I was not able to handle the situation myself and needed expert help. I have referred him about five or six that I recall offhand. In all of these except one, the patient has come back to me. We now have two cases of ulcerative colitis that have been referred to us by psychiatrists. We are still struggling with one of them, and the other is in remission.

I ask the patients that I have sent to the psychiatrist and who come back and say they don't want to go back to him anymore, why don't you want to go back. "Well, he just sits there and writes, he never says anything, doesn't do anything for me, just writes things down." He doesn't let them lean on him like I do. The psychiatrist is pretty objective and has to be. I think the psychiatrists who have allowed the patient to "transfer" to them have had the best results.

I also feel that regional enteritis is a psychosomatic disease and I think that the disease process and background are similar but the soil is different. We have seen, and I'm sure Dr. Crohn has also, patients with involvement of the entire small intestine and colon simultaneously. We now have two patients with enteritis whose mothers have ulcerative colitis.

DR. CROHN: COMMENT: I have a family with regional ileitis in one member, ulcerative colitis in

another member, segmental colitis right-sided colitis in the third member and duodenal ulcer in the fourth.

Q. Are the eye findings in regional ileitis more significant in regional ileitis than in ulcerative colitis?

DR. CROHN: Eye findings in regional ileitis are less significant; they are much more significant in ulcerative colitis particularly in right-sided segmental colitis. Xerophthalmia, or vitamin "A" deficiency, phlyctenular conjunctivitis is very common in ulcerative colitis. Conjunctivitis, iritis, iridocyclitis and corneal ulceration, are all very common manifestations of ulcerative colitis, right-sided colitis and to a lesser extent of regional ileitis. It is something that the ophthalmologist has learned with a great deal of pain over a long period of time. We have seen actual blindness due to bilateral corneal ulceration in a man who was treated by an ophthalmologist for years; and nobody remembered to think that this man was suffering with diarrhea all the time.

Q. TO DR. CROHN AND DR. MACHELLA: Would it not really simplify the management of non-specific inflammatory diseases if the clinician regarded regional ileitis and ulcerative colitis as actually one disease. The differences in pathology and the differences in the clinical course being merely differences due to the location of the inflammatory regions.

DR. MACHELLA: That is exactly the way I feel about the two diseases. There is, however, one point that disturbs me about the attitude. Dr. Crohn might be able to clear this up since he has had a more extensive experience than I have. If there is anything to the predisposition to carcinoma in ulcerative colitis and it looks like there probably is, why don't we see carcinoma of the small gut in regional enteritis?

DR. CROHN: Dr. Shields Warren who delivered a paper at the AMA last June in Chicago, made the point that they are two entirely different diseases. Ulcerative colitis is one disease and regional ileitis another. In my discussion of his

presentation I could not agree. I thought there are so many similarities pathologically and clinically between the two diseases that I couldn't completely separate the two.

Dr. Machella noted cases which began with ulcerative colitis, which ran a severe course of ulcerative colitis and suddenly developed a diffuse ileojejunitis as a complication. In a case seen some years ago an ileostomy and colectomy had been performed on a case of ulcerative colitis. An attempt to take down the ileostomy and replant it in the sigmoid colon resulted badly. Within three weeks the ileostomy had to be restored. At the time of the reestablishment of the ileostomy the surgeon was amazed to find a diffuse ileojejunitis. Also you see cases which beginning as ileitis, do badly, and end up with a progressive ulcerative colitis. Or one sees cases which begin originally as combined ileitis and colitis with various mixed forms. There are, however, differences in clinical manifestations of the two diseases. For instance, in women ulcerative colitis, the severity of the course is characterized by skipped menstruation, amenorrhea. The prognosis and severity of the disease in ulcerative colitis can be judged by the degree of menstrual disturbance or the degree of amenorrhea.

The first reappearance of menstruation is the best prognostic symptom. As soon as normal menstruation is reestablished the prognosis becomes favorable. No matter how bad a case is of ileojejunitis, she rarely skips a menstrual period.

Take the question of pregnancy and parturition. The ileitis case or the ileojejunitis case goes through pregnancy perfectly well; will deliver a perfectly normal child and will probably not have a recurrence of the disease. If she hasn't had a recurrence during the pregnancy, she probably will not have a recurrence later. On the other hand, I know of nothing worse than pregnancy in ulcerative colitis. During the course of pregnancy they may be well, and

the diarrhea is controlled. Within three weeks or a few weeks after the delivery of a child, the ulcerative colitis patient has a tendency to have a recurrence of all the symptoms with marked severity.

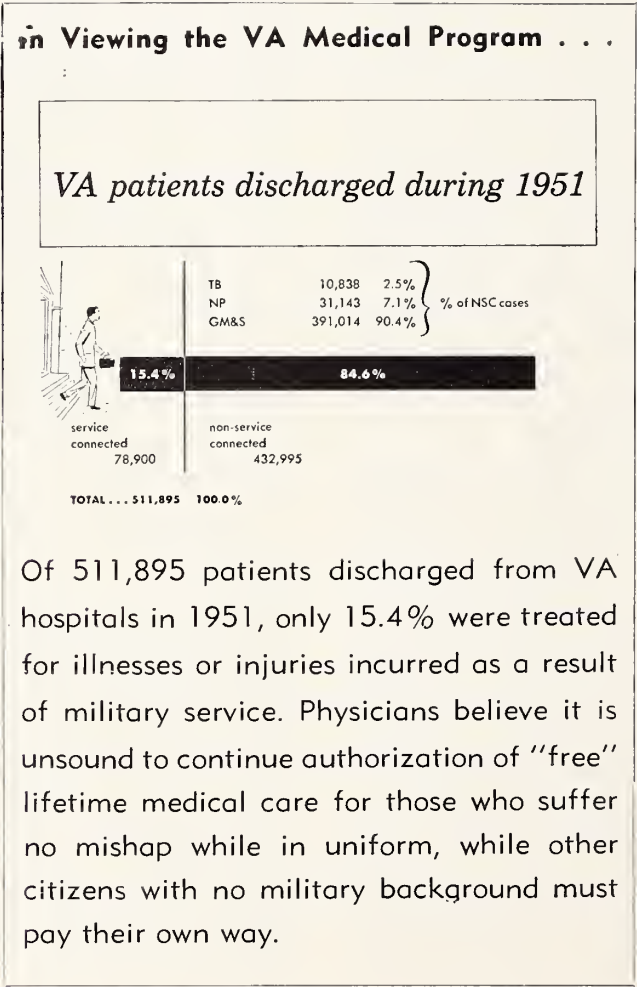
There are similarities and there are marked clinical differences but behavior of the two diseases toward pregnancy and parturition particularly and the behavior of menstruation is to my mind a very definite differentiation between the two types of disease.

Q. Would either essayist comment on when the continuity of the bowel would be reestablished after an ileostomy was performed?

DR. CROHN: You were probably too young to be present at the American Gastroenterological Association, when Dr. Daniel Jones of

Boston was alive and was doing ileostomies without colectomy. Dr. Jones was asked:—have you ever taken down an ileostomy and reconnected it? And Dr. Jones who had a very keen sense of humor said, “Yes, I have, five times. Twice the patient died; the next two patients were materially worsened by taking down the ileostomy and the fifth one, I never heard from and never want to.”

DR. MACHELLA: My answer to that would be to take down the ileostomy and re-establish continuity only if the emotional factors had been solved. The patient then might have a good chance of getting along unless something else turned up and upset him. The same sort of thing applies to pregnancy. If the woman wants to become pregnant and wants the baby, she will do well; if she doesn't, she will do poorly.



ARTICLES OF INTEREST

MULTIPLE SCREENING

Its Place in the Baltimore Chronic Illness Study

DEAN W. ROBERTS, M.D.* AND CHARLES M. WYLIE, M.B., CH.B

The Commission on Chronic Illness is a temporary national, non-governmental, research and educational organization founded in 1949 by the American Medical Association, the American Public Health Association, the American Public Welfare Association, and the American Hospital Association.

A number of new clinical problems have been added to the already numerous complexities of the study of chronic illness in Baltimore, first described in the pages of this JOURNAL over a year ago.¹ The final phase of this study is the operation of a so-called "multiple screening" clinic, being arranged for the Fall of this year. The purpose of this article is to describe some of these clinical problems.

The idea of screening for signs and symptoms of a disease is already well known to Baltimore physicians. There has not been, however, any prior experimentation here with multiple screening although the process has been tried in Richmond, Indianapolis, and Atlanta, to name a few other cities.

Before describing some of the clinical problems we are encountering, a progress report on the earlier phases of the study is in order so that the purpose of the screening clinic can be best understood. Much has happened since this study carried out by the Commission on Chronic Illness was first described² in the JOURNAL. Approximately 4000 households,

chosen to be representative of the City of Baltimore and including 12,000 persons, have been interviewed by trained lay interviewers who have recorded in detail the illness and disability reported. This phase of the study was completed early in September with a most gratifying response from Baltimore householders. The interviews required an average of about 40 minutes each. Based on the first nine months of the survey, the interviews were successfully completed in 97.6% of the households, the occupants could not be located in 2.1%, and 0.3% declined to be interviewed. This high response rate is important to the statistical reliability of the data obtained.

This phase, which is now complete, included very little that was new or different from previous illness surveys. However, such surveys leave unanswered a number of important questions about chronic illness: To what extent do people actually have the conditions they report to a lay interviewer? Do they fail to report conditions of which they are aware? Does the informant, usually the housewife, have accurate and reliable knowledge of the health conditions of other members of the family? How much chronic illness exists that is not reported because it had not yet been diagnosed? To state it broadly—what is the kind and degree of error—resulting from under and over reporting—in statistics derived from household interview surveys of illness?

CLINICAL EVALUATION STEP

In order to answer these questions and to study the kind of care needed by the chronically ill, arrangements were made for a detailed clinical evaluation of a sub-sample of approximately 10% of those persons in the household interview step. A special evaluation clinic was established for the purpose at the Johns Hopkins Hospital which undertook the evaluation through a contractual agreement with the Commission on Chronic Illness. The evaluation was designed to provide a comparison between illness data derived from systematic household interviews and corresponding data derived from a careful medical work-up supplemented by laboratory tests, specialist consultation, and medical data obtained from private physicians and hospital records. The

* Director, Commission on Chronic Illness.

¹ The following is quoted from the minutes of the Council of the Medical and Chirurgical Faculty of April 27, 1953: "Council unanimously approved the study in principle, and suggested further that in order to render additional assistance, appropriate information be published in the Maryland State Medical Journal."

² Roberts, Dean W., Maryland State Medical Journal, June 1953, p. 297.

medical work-up would be a fairly close approach to an absolute determination of the illness status of the person within the limits imposed by current medical knowledge, available tests, etc. It would also permit a consideration of the degree of disability, the potentialities for rehabilitation and the kind of care needed, which was not possible from the sketchy information available from interview data alone. By mid-July 385 persons had been evaluated, out of the 1000 for whom this procedure was planned.

The evaluation step has been full of surprises and no small number of disappointments. It is the novel part of the study and also the most important part. The first (and continuing) difficulty was in persuading selected individuals to come to the evaluation clinic. It had been assumed, perhaps naïvely, that people would welcome the opportunity to get a thorough diagnostic evaluation as a part of the study. This has been true, only for a small group. Of those invited to the clinic 31% have been classified as outright refusals. This figure is not quite as bad as it at first sounds. It includes a substantial group who have moved away from the city or to a new address that could not be located, also a small group who died after being included in a household interview, a few Christian Scientists, and a substantial group who were obviously too disabled or ill to undertake a trip to the clinic.

Other refusals can best be described in terms of "attitudes" toward medicine, hospitals, and doctors. Some related previous disagreeable experiences with clinics. Others had a complete lack of confidence in physicians. Some were afraid they would be "experimented" on. A few mothers did not want their teen-age daughters "examined" and refused to come even though assured that the gynecological examinations would be omitted. A rather large group declined on the basis that they felt well and they saw no point in an examination unless they were sick. Some would have come if the clinic had offered treatment, but refused when it was made clear that the evaluation clinic was limited to diagnostic examination. One of the larger and most interesting groups of refusals were those who stated or implied, "If there is anything wrong with me, I don't want to know about it." This was predominantly an elderly group and may represent an attitude that goes with advanced age. Or they may be persons who are unaware of medical advances and who lack an appreciation

of what modern medicine can do to help them. In any event, they probably represent the kind of person who does not seek medical care until illness is far advanced and beyond the stage when treatment can be most effective.

There also have been persons who declined the evaluation because they are under regular periodic medical supervision. These individuals see no personal advantage in an additional examination. In such cases it has sometimes been possible to get sufficiently detailed and complete information from the personal physician to fulfill the requirements of the study for evaluation data. However, such information is not fully comparable to that obtained in the evaluation clinic where examination procedures, laboratory tests, and measurements of vision, hearing, blood pressure, etc. have been substantially standardized.

Several hundred Baltimore physicians have been in contact with the study in relation to their private patients. At the time of household interview, if illness is reported, the name of the physician in attendance is obtained. Permission to get additional medical information from the doctor is requested. If that person falls in the 10% sample selected for clinical evaluation, a personal letter is sent to the physician. In a few days the letter is followed by a telephone call.

The purpose of the telephone call is to obtain any pertinent information from the physician as to the nature of the illness and the resultant disability and to determine whether or not there is any reason why the patient should not be invited to come to the clinic. In some instances there are distinct medical contraindications to a clinic appointment such as when persons have a history of a recent coronary occlusion and when they are aged and the personality of the patient is such that the physician has asked that the patient not be invited to the clinic. In a great many instances when the patient has hesitated to come to the clinic, the family physician has urged attendance and has convinced the patient to come in.

This report would be incomplete if it did not add that in three or four instances the reaction of the family physician to the study has been unfavorable in that he felt that the evaluation in the clinic interfered with his relationship to his patient. Such reactions were usually the result of misinformation or a lack of information about the study and clarification

has not been difficult. If for any reason a physician requests that a particular patient of his not be invited to the clinic, this request is honored. Fortunately there have been only a few such cases—if there were many they would reduce the “representativeness” of the sample and thus the value of the data.

PLANS FOR THE MULTIPLE SCREENING STEP

This Fall the study moves on to another step which promises to pose many problems. Multiple screening has been tried in many sections of the country and has been variously described. Some have regarded it as a major instrument in the detection of asymptomatic chronic disease, and thus an important aid to treatment early in the course of disease when the prospect of success is greatest. Others criticize screening on the basis of the expense, the mental anguish caused by false positive reports, the false sense of security in the person whose tests are all negative, the injection of a third party into the physician-patient relationship, and the inadequacy of the tests that are currently available.

The Commission on Chronic Illness, a national research and educational agency, will close its books and go out of existence in less than two years. Before winding up its affairs it will need to make a critical assessment of multiple screening in order to formulate properly its recommendations. This assessment will involve a careful review of the experience reported by others and, in addition, a direct exploration of certain problems and possibilities in a screening step conducted as a part of the Baltimore Chronic Illness Study.

The Purpose of Screening

For some years the miniature film chest x-ray clinics have screened out those persons who needed further examination for possible tuberculosis. Annual diabetes detection clinics have sorted out persons who required additional study for diabetes. For the first time in Baltimore, however, a combination of several tests will be used experimentally in one clinic to screen for a number of abnormal conditions.

Multiple testing has the same goals as testing for a single disease, i.e. the early detection of certain conditions which might benefit from immediate medical care, and the referral of persons possibly having these conditions to their personal physician

for further diagnosis and treatment if necessary. Multiple screening may prove to be an important tool in the control of chronic disease, where early detection may result in successful treatment before an irreversible phase of the disease is reached.

It might also be mentioned that multiple screening is an adjunct to the annual physical examination procedure. It can have value in that the physician's time is conserved by enabling him to concentrate his efforts on persons who are more likely to have disease or abnormalities.

At the Baltimore multiple screening clinic there will be no physical examination. The following tests will be given: electrocardiogram, chest x-ray, blood pressure reading, height, weight, urine and blood sugar determinations, tests for albuminuria and hemoglobin level, serological test for syphilis, vision and hearing tests and a dental examination.

Several other tests were considered for inclusion but were discarded either for technical reasons or because it did not appear that they would contribute materially to the information needed by the Commission. In the selection of the tests to be used, the method of their use, the interpretation of the findings and the manner of making reports to patients and physicians, the Commission had the advice of a technical committee³ composed primarily of practicing physicians who reviewed the prospectus for the project and made many valuable suggestions. Among the tests discussed at length by the Committee were those related to heart disease. These include the electrocardiogram, heart size and shape as revealed by chest x-ray, blood pressure and two questions designed to ask about symptoms of exertional discomfort.

The EKG

The electrocardiograph has been in use for many years. With the introduction of unipolar limb leads and chest leads, the total procedure has now become too time consuming to be suitable for rapid application to large groups of people. It has been found elsewhere,⁴ however, that when the lead I tracing alone is used as a screening test, approximately the

³ Dr. Lewis P. Gundry, Dr. Edwin B. Jarrett, Dr. Louis A. M. Krause, Dr. Joseph L. Lilenthal, Dr. Henry J. L. Marriott, Dr. Perry F. Prather, Dr. Raymond K. Thompson, Dr. Huntington Williams and Dr. George H. Yeager.

⁴ Dawber, T. R. et. al. *Circulation* 5: 559, 1952.

same number of cases of heart disease can be detected as if a 12 lead EKG had been taken.

The increased accuracy of the twelve lead EKG becomes apparent, not on the persons who have heart disease, but on those who are normal. Twenty per cent of persons without heart disease are classified as "doubtful" or "abnormal" with the lead I tracing alone. Many fewer persons without heart disease, however, are classified as "doubtful" or "abnormal" if the twelve leads have been taken.

It is apparent that the lead I test, resulting in the wrong referral of almost 20% of all persons going through the clinic, would be quite unsatisfactory by itself. The defect can be overcome, however, by carrying out a more thorough EKG on those whose lead I tracings appear suspicious. In this way, the time-consuming test is carried out only on one-fifth of the persons, with almost the same number of cases being detected and without the burden of an excessively large number of false positives.

This test illustrates the problem of false positives which applies in varying degree to all screening tests. The lead I EKG, used in the above manner, may wrongly refer about three false positives for each case of heart disease correctly referred. This could produce a heavy burden of unnecessary mental suffering if these persons with a normal heart were given the wrong impression, even though later corrected, that something was wrong with their hearts. They also could properly complain of the expense of establishing the absence of heart disease after a test had wrongly raised a doubt. To reduce such false positives to a minimum, the 12 lead EKG will be carried out on all persons with a doubtful lead I tracing before the person leaves the clinic. As a further guard against unnecessary worry, the clinic will emphasize that a positive test does not make a diagnosis, but merely indicates the need for further examination and testing by their personal physician. A basic rule of the clinic procedure is that all abnormal test results are sent to the family physician for interpretation to the patient.

The Chest X-ray

Second in the tests for heart disease is the miniature film chest x-ray, in which changes in heart size and shape will be noted. It is well known, of course, that this is an insensitive test. Many cases of heart disease and hypertension show no detectable

heart enlargement. Some additional cases will be found, however, who were missed by the electrocardiogram.

The Blood Pressure

The third test for heart disease and hypertension is the blood pressure reading. The difficulties involved in this test are only too well known. The lack of agreement on what are normal values ranges from Robinson and Brucer's belief that 120/80 is abnormal at any age⁵ to the investigation by Master et al.,⁶ suggesting that 160/100 can be normal around the age of 50. One of the values of including this test is that we will obtain, under standardized conditions, the blood pressures of a random sample of the adult population of the city.

Involved also in the difference of opinion on blood pressure is the realization that although a significant number of persons in their fifties have readings of 160/100, this does not necessarily mean that such a reading is conducive to a long and active life. This once again brings to light the old controversy that the aim of medical supervision is the maintenance of optimum values, not of average values. Many physicians, on the other hand, can bring individuals to mind with extraordinarily high blood pressures who are capable of a hard day's work.

What is Hypertension?

Not too widely known is the fact that the obese arm is likely to give systolic and diastolic readings which are too high. This error may exceed 30 mm. of mercury.⁷ It is suggested that this should not effect the level at which overweight persons are referred. An obese person with a raised sphygmomanometer reading will be helped by a reducing diet, whether a true hypertension is present or not.

The blood pressure levels above which persons will be referred to their physicians as possible hypertensives have been made higher for older age groups at the screening clinic. Below 35 years of age, any person will be referred whose blood pressure is over

⁵ Robinson, S. G. and Brucer, M. Arch. Int. Med. 64: 409, 1939.

⁶ Master, Garfield & Walters: Normal Blood Pressure & Hypertension: New Definitions. Philadelphia (Lea & Febiger, 1952).

⁷ Ragan, C. & Bordley, J., Bulletin. Johns Hopkins Hospital 69: 526, 1941.

150/90 mm. Hg. Between 35 and 50 years, a critical level of 160/96 will be used. Over 50 years, a pressure above 170/100 will result in referral to the family physician. Figure 1 compares these screening levels with the data collected by Master, Garfield and Walters.^{6a}

Symptoms of Heart Disease

Considerable study has been made of the use of questions concerning symptoms of "heart disease" in screening for these conditions. Only two questions have been found to have any degree of specificity in testing for cardiac disabilities.⁸ These questions, both related to discomfort on exertion, are: (1) "Do you ever have distress, pain or an uncomfortable feeling in the chest while walking on the street or up inclines or steps?" And (2) "While walking, are you forced to stop in order to rest?" A positive answer to both questions will result in referral to the family physician.

It can thus be seen that four different types of tests are being used in screening for heart disease and hypertension: 1) The electrocardiogram, 2) The chest x-ray, 3) The sphygmomanometer reading, and 4) Symptoms of heart disease. While each of these tests will pick up only certain types of cases, all four, particularly if used in combination, should be successful in screening off the major proportion of cases who require medical supervision. It is estimated that the 7,000 persons who will be invited to this clinic will include about 280 previously unknown cases of heart disease and hypertension.

Screening for Obesity

It can be argued that there is no point in screening for obesity. If a person is substantially overweight, he probably knows it and certainly his physician does—if the individual has a physician! On the other hand, the recent evidence on the importance of obesity in relation to heart disease, diabetes, arthritis, hypertension, and longevity in general seems to warrant inclusion of measurement of height and weight in the tests. Persons who are 30% or more overweight will be urged to seek medical advice from their physician. Those who are 20% to 30% overweight will be referred if some other condition,

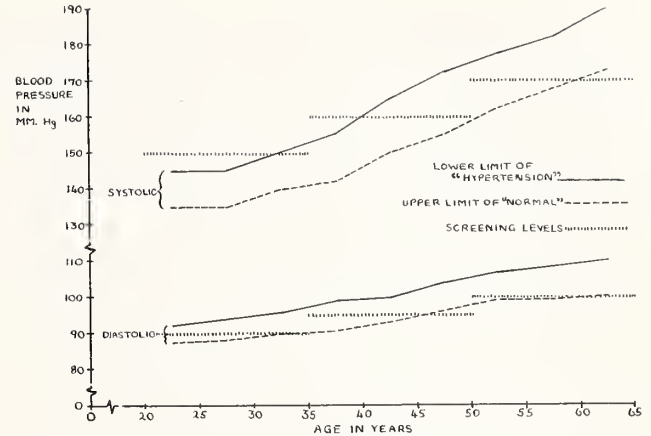


FIG. 1. Relation of screening levels to upper limits of normal blood pressure and lower limits of hypertension (averaged for males and females).

such as family history of diabetes, emphasizes the need for strict weight control. Lesser degrees of obesity will be called to the attention of the person for their information.

Tests for Diabetes

Limitations of space prevent a detailed account of all of the other tests. Among the most difficult to handle are the tests for diabetes. Both blood sugar and urine sugar will be tested, but it will be impractical to ask people to come to the clinic in a fasting state. Persons with a urine sugar level of one plus or more, or a blood sugar level of 160 mg.% (or 130 mg.% if no food is taken within one hour before attending the clinic) will be offered a glucose tolerance test at a later date; those with an abnormal curve will be referred to their family physician.

The Time and Place

It is planned to operate the screening clinic for a limited period of about 10 weeks probably beginning about October 4. This is a single experimental clinic and there is no thought to continuing it as a service program. Dr. Robert H. Riley has graciously consented to allow the Commission on Chronic Illness to use Bennett Hall at 20 East 23rd Street for the Clinic. Those persons (approximately 7000) who were included in the household survey, who are over age 16 and who were not in the evaluation sample will be invited to come in on an appointment basis. There is adequate parking space and a person should be able to complete all the tests in about an hour.

^{6a} Ibid. page 560.

⁸ Phillips, E., et al. Amer. H. J., 45: 3, 1953.

The Commission needs the active support of the physicians of Baltimore during the remaining months of this study. The study is a complex and difficult one and we hope that it can be completed successfully without producing any problems between doctors and their patients. We recognize certain inherent hazards, however, in any study gathering detailed medical data on a cross section

of the population of the city. If any incident for which we are responsible develops with one of your patients, we hope you will call it to our attention in order that we may endeavor to rectify the situation. (Telephone PEabody 2-7133.) Data from this study will be of interest to the medical profession and will be particularly useful in helping Maryland make appropriate plans dealing with the mounting problem² of chronic illness.

PRISONER OF WAR RETURNS*

CAPTAIN WILLIAM SHADISH

Physician
POW Camp
North Korea

It seemed incredible to me that I had missed something. Like all other good and true alumni I believed that my school ranked right up there on top. The curriculum was thorough and complete. But I found out differently. The Communists pointed out to us that something had been neglected in our medical training. It was like this.

We had been prisoners of war for a good many months and hadn't seen a scientific medical publication in all this time. We approached our captors in an attempt to procure any type of medical literature, so that we might keep the cobwebs from our minds. The answer we received in essence was this: "We communists feel that there will be much time for your study of medicine in the future, but while you are here with us we shall give you the opportunity to learn the most important factor in medicine.—Whom shall you treat and save from death and whom shall you not treat. You do not seem to realize that medicine, like everything else in life, without exception, cannot be divorced from politics. Everything is primarily political in nature. The other purposes are secondary." What a revelation! It would seem the Hippocratic oath has been rewritten in the Soviet countries.

In all there were nine American physicians who were captured by the Communists—five survived. Since repatriation the question most asked has been, "Were you allowed to practice your profession in

the prison camp and were you regarded as a physician?"

You be the judge. Briefly, this is what happened.

In the beginning the enemy seemed to have no definite plan for providing medical care for the prisoners. During this period, roughly 6-8 months, we were permitted to care for the sick and wounded under existing conditions. These were:

1. Extremely poor diet—almost entirely carbohydrate with caloric content at or below basal requirement.

2. Bitterly cold climate often beyond minus 30 degrees Fahrenheit.

3. Pathetically insufficient clothing—no blankets or bedding of any kind and heavy outer clothing was at a premium.

4. Primitive housing, often open to the environments, with heat practically unheard of.

5. Shocking lack of sanitation facilities—not even shovels available for digging latrines in the frozen ground.

6. Extremely high rate of diseases—most common were dysentery, both bacillary and parasitic in origin, and lobar pneumonia. As one would expect with troops in a state of severe malnutrition, the mortality rate was astoundingly high. In one camp called Death Valley, where I was interned, the mortality rate of the prisoner group was between 60% and 70%.

7. A negligible amount of medication and surgical equipment—enough for treating only 1% or 2% of those requiring medicine or treatment.

As difficult as the problems were, the Communists continually made things worse. They insisted on supervising our work at all times. Any medications prescribed were dispensed only by the Chinese.

* Reprinted by courtesy of the Alumni Bulletin of the State University College of Medicine at New York City.

Invariably the medications were either refused completely or cut in volume so drastically that they could no longer serve their purpose. This was especially true when the patient was one who steadfastly resisted the efforts of Communist indoctrination. In these instances particularly, were improvisations necessary; such improvisations even though of little specific medical value, did much towards boosting the morale which was fearfully low. In fact this morale boosting constituted the most basic aim of our practice in this early period. We had little else to work with.

In July 1951, about 8 months after capture, we physicians were relieved of our medical duties by the Communist authorities and sent to the officers' compound "for study." From this time forward we were specifically forbidden to practice medicine in any manner at any time. We did continue to administer to those fellow prisoners who required aid, but of necessity this was done in secrecy and, of course, without a legitimate source of medicine.

About this same time a somewhat larger supply of medications became available. These were administered by Chinese medical students none of whom were as competent as a good Army medical corpsman. The food also improved to at least a minimal diet, calorically speaking, and some little protein and vegetables were added from time to time. The mortality rate of course decreased rapidly to practically nothing, although the state of nutrition was

such that dietary deficiency diseases were evident in most prisoners right up to repatriation.

What is most infuriating is that the deprivation was deliberate. Tons and tons of propaganda materials, books, magazines and newspapers, including the "New York Daily Worker," reached us. And yet we heard "no transportation available for food or medicines." The Marxist-Leninist literature explains this. For instance it is pointed out that when "a group of subjects are reluctant to accept (Communist) indoctrination, the most effective method of dealing with them is first to deprive them of the necessities of life to a point that is sub-minimal, and then to offer a slow steady increase in these necessities contingent upon at least passive acceptance of the program. Steadily recalcitrant individuals can be controlled by individual "corrective measures." "Corrective measures" is a Communist term for torture, death or both.

These experiences have left an indelible impression upon me. The Communists did their utmost to teach us whom to treat and who did not merit treatment. But somehow we remained unimpressed. Murder, deceit and fabrication do not appeal to mature minds reared in our environment of freedom.

WILLIAM R. SHADISH
Captain, MC, USA
10306 Insley Street
Silver Spring, Maryland

INDIAN COMMISSIONER SEES IMPROVED HEALTH UNDER HOSPITAL TRANSFER

The A. M. A. Washington Letter, No. 85

Commissioner of Indian Affairs Glenn L. Emmons believes that the law transferring supervision of Indian Bureau (Interior Department) hospitals to Public Health Service (Department of Health, Education, and Welfare), effective next July 1, will go a long way toward alleviating poor health conditions in Indian areas. Many of these areas, he declared in an address, have been "practically untouched by the great advances in public health protection which have taken place throughout the country during recent decades." He said the Bureau for several months has been building up the staff of professional sanitarians, health educators and other health specialists in preparation for the changeover next year. The Indian bill is among the administration health measures endorsed by the American Medical Association.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

The annual outing of the Allegany-Garrett County Medical Society was held on Wednesday, August 4, at the cottage of Dr. C. C. Zimmerman, at Deep Creek Lake.

Food was prepared and served under the direction of Dr. Fuller Whitworth and Dr. Frank Cawley. Boating and swimming arranged by Dr. James Stegmaier, and social arrangements and games under the auspices of Drs. James Hallinan and Howard Tolson.

The last of July Dr. Arthur Jones assumed his duties as the Garrett County Health Officer.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

SECTION ON INTERNAL MEDICINE*

THE COMMITTEE FOR A RESOLUTION REGARDING THE PROPOSED BETHLEHEM STEEL PLAN, authorized to act for the Section on Internal Medicine of the Baltimore City Medical Society, have carefully reviewed the proposed Plan for Bethlehem Steel employees per letter April, 1954 from the Maryland Medical Plan, Inc. requesting a vote for or against, and inviting comments. Comments and recommendation are respectfully submitted to you for transmittal to the President and Trustees of the Maryland Medical Plan for consideration.

The Section on Internal Medicine is in favor of the principle of prepaid medical care. It is the sincere desire of the Section on Internal Medicine to cooperate to provide the highest type of medical care at a fair and reasonable cost to the subscribers.

* As presented to Francis Gluck, M.D., Chairman, Section on Internal Medicine.

It is the studied opinion of the Committee that every prepayment plan should aim to provide the broadest possible coverage.

The proposed plan for Bethlehem Steel Employees contains certain inequities and shortcomings which we believe operate against the best interests of both subscribers and specialists in the field of Internal Medicine. In so doing it fails to provide the highest type of medical care.

First and most important is the fact that the plan fails to recognize the existence of specialists in Internal Medicine and related subspecialties. This is unrealistic and is contrary to accepted, current medical practice. The attached copy of requirements for admission to examination by the American Board of Internal Medicine points out the minimum fund of experience and training that the Internist must bring to bear in the treatment of patients. These requirements are as stringent and demanding as any set down by any certifying board in the surgical specialties. The period of postgraduate training is as long and arduous for the Internist as it is for the Surgeon. Additional training and certification in Internal Medicine is required for admission to examination by appropriate Boards in the subspecialties.

It is the opinion of the Committee that any Plan that does not provide for care by specialists in Internal Medicine and its subspecialties fails to provide adequate care for the seriously ill patient. Often Internist or qualified Subspecialist is summoned to make the investigation necessary before correct and effective therapy can be instituted.

The Bethlehem Steel Plan obliquely recognizes the existence of specialists in fields other than surgery by providing a \$15.00 consultation fee, but there are no criteria for consultants. Furthermore, the Plan fails to provide for a patient treated directly by a specialist in Internal Medicine or subspecialty.

The question of the benefit to participating specialists in Internal Medicine and subspecialties is, under the circumstances, not considered in the proposed plan. However, these specialists are called

by their colleagues in Surgery or General Practice to provide consultations. The benefit provided for such consultation, upon the quality of which the patient's life may depend is the same as provided for removal of a splinter by a surgeon. It is \$20.00 less than provided for the aspiration of the pericardial sac. The Internist is as well qualified to perform such aspiration as the general surgeon, but he cannot be paid for it under the proposed plan.

It is the opinion of this Committee that in consideration of what has been stated above, the inequities of this benefit schedule need no further elaboration. Therefore, in view of the above, serious shortcomings of the proposed Plan, this Committee makes the following recommendations:

1. A distinction should be drawn between Specialists in Internal Medicine and General Practitioners. For the purposes of the Plan an Internist should be defined as a physician certified, or declared eligible to be admitted to examination by the American Board of Internal Medicine; and/or a physician who is a Member of the American College of Physicians. Furthermore, for the purposes of the Plan, appropriate authority in the Medical Schools in the City of Baltimore may designate any teaching staff member in the Department of Medicine, or subspecialty, as an Internist.

2. Provisions should be included in the proposed Plan for benefits for care by specialists in Internal Medicine and subspecialties.

3. Provision should be made for a Benefit Schedule for specialists in Internal Medicine and subspecialties, in keeping with the type of service rendered. The scale for Medical Specialists should be on a par with that for Surgical Specialists and distinct from the one for General Practitioners.

4. That funds for the above should be made available by adjusting the current or proposed Benefit Schedule without increasing subscribers rates.

5. That representatives of the Maryland Medical Service, Inc., and this Section on Internal Medicine meet to adjust these matters.

The Committee of the Baltimore City Medical Society for a Resolution Regarding the Proposed Bethlehem Steel Plan, June 29, 1954.

CONRAD ACTON, M.D., *Chairman*

KATHERINE BORKOVICH, M.D.

JACK WEXLER, M.D.

THE AMERICAN BOARD OF INTERNAL MEDICINE

Requirements for admission to Examination and Certification

Each applicant for certification by this Board must satisfy the qualifications listed below. I) General Qualifications A, B, C, D. II) Professional Qualifications A, B, C, D. For exceptions to the requirements C and D under Professional Qualifications, see Page 3, Paragraph G.

I. General Qualifications

A. All candidates must be citizens of the United States or Canada.

B. All candidates must present evidence of satisfactory moral and ethical standing in the medical profession.

C. All candidates must be active members in good standing in their County and State medical societies in their state of legal residence. Under unusual and exceptional circumstances the Board reserves the privilege of modifying this requirement. . . .

D. Canadian citizens applying for admission to examination must be active members of the Canadian Medical Association.

II. Professional Qualifications

A. Graduation from a medical school approved by the Council on Medical Education and Hospitals of the American Medical Association at the date of graduation.

B. Satisfactory completion of an approved internship of not less than twelve months. . . .

C. Approved residency or fellowship training in internal medicine according to the following plan (Plan A) or one of the alternate training plans. . . .

Plan A. a residency or fellowship in internal medicine for a period of not less than three years in a hospital or other institution approved by the Council on Medical Education and Hospitals of the American Medical Association for residency or fellowship in internal medicine. In addition, two years of practice of clinical internal medicine will be required. The Board will accept the following equivalents as satisfying one year only, of the three years of residency or fellowship to which this paragraph refers:

1. A second year (or a part thereof) of approved internship in a hospital approved for resident training in internal medicine if limited to the medical service (or medical specialties noted under 2) for one year and if recognized as being the equivalent of an assistant residency by the Medical Director of the hospital and the Chief of the Medical Service.

2. One year of approved residency in one of the medical specialties: Allergy, Cardiovascular Disease, Gastro-Enterology, Hematology, Pulmonary Diseases, Neurology, Pediatrics, and Psychiatry.

3. One year of approved residency in Pathology.

4. One year as a graduate student or as an instructor in an approved medical school on a full time basis in Bacteriology, Biochemistry, Pathology, Pharmacology, Physiology, or Internal Medicine.

5. An advanced degree in the fundamental sciences.

D. Alternate Training Plans: The Board firmly believes that the plan of intensive training prescribed above offers the

best opportunity for a young physician to prepare himself to meet his responsibilities as a specialist in internal medicine. It is recognized, however, . . . Accordingly the Board has modified its previous regulations governing eligibility for admission to examination. In doing so the Board has not modified its standards of examination. . . .

Principles of Training

The American Board of Internal Medicine is interested in the fact that the candidate has embarked on a career of study voluntarily and has thereby expressed the desire to excel and to participate personally in the world's progress in Medicine.

Preparation must be based on years of continuous thoughtful study. Therefore, in suggesting a program for those who wish advice, the Board hopes to assist the candidates to avoid inferior and superficial programs which may lead to failure and disappointment in later years.

The Board believes that all internists should have a sound fundamental knowledge of Anatomy, Bacteriology, Biochemistry, Pathology, Pharmacology, and Physiology. Such knowledge is essential to the continued progress of any internist. The Board anticipates that adequate training will be obtained in the basic sciences as applied to internal medicine during a formal three year residency program.

The Board wishes to emphasize that time and training are but a means to the end of acquiring a broad knowledge of internal medicine which the candidate must demonstrate to the Board in order to justify it in certifying that he is competent to practice internal medicine as a specialty. The responsibility of acquiring the knowledge rests with the candidate. The responsibility of maintaining the standards of knowledge required for certification devolves on the Board. . . .

MONTGOMERY COUNTY MEDICAL SOCIETY

DEWITT E. DELAWTER, M.D.

Journal Representative

On Thursday July 29, 1954 the Montgomery County Health Department employees gave Dr. V. L. Ellicott a farewell dinner at the Indian Springs Country Club. At the dinner Dr. Robert A. Hare, President-elect of the County Medical Society presented Dr. Ellicott with a desk set from the Society as a farewell gift in remembrance of the fine cooperation that has existed between the Society and the local health department.

Dr. Ellicott began his new work on August 1, 1954 as director of the Department of the Aged and Chronically Ill of the State of Maryland. The Society

wishes him success and happiness in his new position.

Dr. K. F. Welte has left the local Chest Clinic to take a new position in Cleveland. Dr. Allen J. O'Neill has taken over the operation of the Chest Clinic.

The President of the Society has appointed Dr. George Sharpe as Chairman of the Diabetes Detection Drive for this year. He will work with interested lay groups in the conduct of the drive. It is hoped that all physicians will give Dr. Sharpe their complete support in this national effort to detect Diabetes.

The President and Secretary of the Society appeared before the County Council in July to request that the local physicians be consulted in the selection of a new health officer for Montgomery County. Our representatives were warmly received and told that their interest and recommendations would be appreciated. A member of the Society has been appointed to serve on a committee for the purpose of reviewing applications and making a recommendation to the County Council.

The coming programs for the Society are as follows:

October 19, 1954—Place—Clinical Center, National Institutes of Health, Bethesda, Maryland.

Program

7:00 p.m. Dinner—Cafeteria

8:00 p.m. "Infectious Hepatitis"—Auditorium

Dr. Norman B. McCullough, Chief, Laboratory of Clinical Investigation, National Micro Biological Institute.

Business Meeting to follow.

November 16, 1954 Dinner Dance—Woodmont Country Club.

The Medical Library of the National Institutes of Health has been made available to the members of the Society on the same basis as to the members of the staff of the Institutes. This is one of the finest and most up-to-date libraries in the Country and we are fortunate to have it in our County to serve as a supplement to our State Society Library in Baltimore.

WASHINGTON COUNTY MEDICAL SOCIETY

SIDNEY NOVENSTEIN, M.D.

Journal Representative

The regular meeting of the Washington County Medical Society was held in conjunction with a picnic at the Potomac Fish and Game Club, Williamsport, Maryland.

Members of the Washington County Dental Society were also invited.

By majority vote, the Society approved the suggestion by the Medical and Chirurgical Faculty that annual dues be collected by the State Society instead of the County Society.

No action was taken by the Society on the matter of the insignia for each Society, as desired by the State Journal.

Malpractice insurance coverage for physicians was discussed and a committee appointed to investigate the rate charged for this type of insurance; and amount of coverage underwritten.

HOUSE COMMITTEE URGES 'FAIR TRIAL' FOR NEW VA ADMISSION POLICY

AMA Washington Letter, No. 64

A resolution adopted by the House Veterans Affairs Committee outlines the committee's attitude toward eligibility of veterans for medical care by Veterans Administration. These points are made:

1. The committee approves (a) the present unlimited hospitalization of service-connected cases, (b) the continued hospitalization of non-service neuropsychiatric and TB cases, and (c) the continued hospitalization of other non-service cases "where beds are available and the veteran does not have the ability to pay for private hospitalization."

2. The committee urges "all veterans' groups and all other parties interested in medical care for veterans" to defer final conclusion on eligibility until the new VA admission policy "has been given a fair trial and a period of operation." Meantime, the committee recommends that no new legislation be considered on the subject of eligibility of admissions.

(In November, 1953, the VA put into effect a new 10-P10 form addendum on which the veteran applying for care of a non-service-connected condition would be asked to list his assets and liabilities. Under the law, however, VA cannot deny admission on the basis of information furnished on the form.)

In its resolution the committee notes that a subcommittee, under chairmanship of Bernard W. (Pat) Kearney (R., N.Y.), last year conducted hearings for a month on the subject of entitlement and eligibility. The committee emphasizes that the subcommittee took testimony from veterans' groups, medical societies (including AMA) and government officials. The committee's resolution is in effect an indorsement, for the time being, of the official policy of the Veterans Administration.

The American Medical Association policy on eligibility of veterans would limit the medical care of veterans to two groups: 1. Those with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated. 2. Within the limits of existing facilities, veterans with wartime service suffering from tuberculosis or psychiatric or neurological diseases of non-service origin who are unable to pay for hospitalization. VA should care for the latter group only until non-government facilities are adequate to assume the responsibility. Care of other non-service-connected cases would be the responsibility of the veteran himself or the community.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

LIBRARY CHATTER

MARY EMILY BERGE

Dr. G. Lane Taneyhill, shortly before his death, presented the library with a collection of books on psychiatry and psychoanalysis including a number of original German works by Freud and his colleagues. They represent an addition to our collection in a field where we are particularly weak. Anyone interested in consulting source material along these lines should find them useful.

Summer's heat and summer's vacations are alike behind us and everyone is back at work invigorated and full of ambition, we trust. This seems an appropriate time to call attention to some of the new books added to the library which may add impetus to the usual autumn fire and zeal.

Stuart-Harris, C. H. **Influenza and other virus infections of the respiratory tract.** London, Arnold, 1953.

A timely subject which should be of special value to the alert "G.P." Knowledge of virus diseases is steadily accumulating and this summary of what is known and what is still vague and nebulous should be most useful to the busy doctor who hasn't the time to wade through quantities of journal articles.

Gertler, M. M., and White, P. D. **Coronary heart disease in young adults.** Cambridge, Harvard Univ. Press, 1954

"A mass of new information, leading to important new insights, is presented in this book, which summarizes the findings of a multidisciplinary investigation at the Massachusetts General Hospital of coronary heart disease in adults under 40."

Burch, G. E., and others. **Spatial vectordardiography.** Phila., Lea & Febiger, 1953.

Goodale, R. H. **Clinical investigation of laboratory tests.** 3rd ed. Phila., F. A. Davis, 1954.

Collens, W. S. **Peripheral vascular diseases; diagnosis and treatment.** Springfield, Thomas, 1953.

Duke-Elder, W. S. **Text-book of ophthalmology; vol. 6: Injuries.** St. Louis, Mosby, 1954.

The long-awaited sixth volume of this definitive work.

Ingalls, R. G. **Tumors of the orbit and allied pseudo tumors.** Springfield, Thomas, 1953.

Mushin, W. W., and Rendell-Baker, L. **Principles of thoracic anesthesia; past and present.** Springfield, Thomas, 1953.

Discusses the pneumothorax problem and its solution, historical background, and methods in use today.

Moore, D. C. **Regional block.** Springfield, Thomas, 1953.

Tanner, F. W., and Tanner, L. P. **Food-borne infections and intoxications.** 2d. ed. Champaign, Garrard press, 1953.

Rouché, B. **Eleven blue men and other narratives of medical detection.** Boston, Little, 1953.

Twelve lively stories of mystery and suspense in which the detectives are doctors—medical inspectors, epidemiologists or research scientists—and the criminals, for the most part, microbes. Two of the stories won the Lasker Foundation award for medical reporting.

Stanbury, I. B. **Endemic goiter.** Cambridge, Harvard Univ. press, 1954.

Manual of clinical mycology. 2d. ed. Phila., Saunders, 1954.

Wittkower, E., and Russell, B. **Emotional factors in skin diseases.** N. Y., Hoeber, 1953.

Shelley, W. B., and Crissley, J. T. **Classics in clinical dermatology.** Springfield, Thomas, 1953.

A biographical sketch of the writer introduces each original description by outstanding dermatologists, past and present. All foreign writings have been translated into English. Beginning with Robert Willan's "On cutaneous diseases," 1798–1808, it ends with the description of "Tropical anidrosis" by Allen and O'Brien in

1944. In many cases, originals from which these classics were taken are available in the Faculty Library.

Duffy, J. **Epidemics in colonial America.** Baton Rouge, La. State Univ. press, 1953.

The first comprehensive study of colonial epidemics since Noah Webster's.

Penfield, W., and Jasper, H. **Epilepsy and the functional anatomy of the human brain.** Boston, Little, 1954.

Haymaker, W., ed. **The founders of neurology.** Springfield, Thomas, 1953.

One hundred and thirty-three biographical sketches prepared for the Fourth International Neurological Congress in Paris. Members of the Medical and Chirurgical Faculty who have contributed sketches to this volume are Doctors David Bodian, on Wickman; W. Horsley Gantt, on Pavlov; and A. Earl Walker, on Elliott Smith, Walter Dandy, and Victor Horsley.

Williams, Roger J. **Free and unequal.** Austin, Univ. of Texas press, 1953.

An internationally-known biochemist discusses the real basis of individual liberty, the extent and character of individual differences. He believes that abandonment of the false concept of "the average man" opens up new vistas in education, medicine, art, religion, race and politics. One of the most stimulating and thought-provoking books we have come across in some time.

Gronowicz, A. **Bela Schick and the world of children.** N. Y., Abelard-Schuman, 1954.

This biography of the famous discoverer of the Schick test is a warm and human story written with great charm and appeal. Dr. Edwards A. Park says, in his epilogue, that Bela Schick "is so simple, open and friendly . . . so good and kind that to become acquainted with him is to love him." After reading this book you will feel that you do indeed know and love him.

In Viewing the VA Medical Program . . .

how VA facilities are being used

	Patients Discharged During 1951			
	TOTAL	SERVICE CONNECTED		NON SERVICE CONNECTED
TB	21,388	10,550	= 2.1%	10,838 = 2.1%
NP	47,673	16,530	= 3.2%	31,143 = 6.1%
GM&S	442,834	51,820	= 10.1%	391,014 = 76.4%
TOTAL	511,895	78,900	15.4%	432,995 84.6%

The medical profession recommends that VA medical core be maintained for treatment of all service-connected cases and temporarily for all wartime veterans suffering from tuberculosis or neuropsychiatric disorders of non-service-connected origin, within limits of existing VA facilities, if they cannot afford private medical care. General medical and surgical patients with non-service-connected disabilities (now 76.4% of all VA patients) should not be entitled to "free" federal medical care.

Health Departments

BALTIMORE CITY HEALTH DEPARTMENT

Birth Record Correction Advisory Service

Since August, 1950 the Bureau of Vital Records of the Baltimore City Health Department and the Legal Aid Bureau of Baltimore jointly have maintained a special advisory service for the correction of birth certificates. The service is particularly designed to aid in the correction of birth certificates of out-of-wedlock children which involve problems relating to adoption, legitimation and paternity.

The advisory service holds sessions on the second Wednesday of every month from 5:00 to 7:00 P.M. in the office of the Director of the Bureau of Vital Records on the first floor of the Municipal Office Building, Lexington and Holliday Streets.

Persons previously reluctant about coming forward, or fearful of embarrassment or exposure have availed themselves of the opportunity to attend these meetings which are private and confidential. The service is particularly advantageous to applicants who are employed during the day and unable to call during regular business hours at either the Health Department or the Legal Aid Bureau offices.

The facilities of the Legal Aid Bureau are made available to persons in low income groups only; all

others are advised to obtain the services of private attorneys.

In four years of operation 1,201 persons have applied for assistance in correcting birth certificates. More than half of these requested aid in situations related to adoption, legitimation, paternity and delayed birth registration. A breakdown of the total for the four year period is as follows:

Adoption.....	222
Legitimation.....	214
Paternity.....	44
Legal change of name.....	72
On basis of usage.....	53
Delayed registration of birth.....	112
Cases referred to other registration jurisdictions.....	50
Cases referred to Legal Aid Bureau.....	86
Cases referred to private attorneys.....	43
Others.....	305
Total.....	1,201

For any information concerning this service, telephone Mr. Sidney M. Norton, Director of the Bureau of Vital Records, PLaza 2-2000, Extension 827.

Huntington Williams, M.D.

Commissioner of Health

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, September 3-30, 1954

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County.....	6	—	2	1	—	—	6	13	4	—	1	—	—	7	10	1	7	—	2
Anne Arundel.....	1	—	—	—	2	—	—	2	3	—	—	—	—	—	7	3	11	—	1
Howard.....	—	—	—	—	—	—	—	2	—	—	—	—	—	—	1	—	2	—	—
Harford.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—
Carroll.....	—	—	—	1	—	—	—	—	—	—	—	—	—	1	1	—	1	—	1
Frederick.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	1	—	—	—
Washington.....	1	—	—	—	—	—	—	1	—	—	—	—	—	2	—	—	5	—	—
Allegany.....	1	—	—	3	1	—	—	—	—	—	—	—	—	—	6	—	—	—	1
Garrett.....	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Montgomery.....	1	—	1	7	2	—	3	3	3	—	4	—	1	—	1	—	4	—	2
Prince George's.....	—	—	—	—	—	—	2	6	1	—	5	—	—	—	8	1	9	m-1	1
Calvert.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Charles.....	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1	—	—	—	1
Saint Mary's.....	—	2	—	2	—	—	—	—	—	—	—	—	—	4	1	—	—	—	1
Cecil.....	—	1	1	2	1	—	1	1	2	—	—	—	—	—	2	—	3	—	1
Kent.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Queen Anne's.....	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Caroline.....	—	—	—	—	—	—	—	—	1	—	—	2	—	1	2	—	2	—	—
Talbot.....	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1	—	—	—
Dorchester.....	—	—	—	—	—	—	—	1	—	—	—	—	—	—	2	—	3	—	—
Wicomico.....	—	—	2	—	—	—	—	1	—	—	1	—	—	—	6	—	15	—	1
Worcester.....	—	—	—	—	—	—	1	—	—	—	—	—	—	—	3	—	1	—	—
Somerset.....	—	—	—	—	—	—	7	—	—	—	—	—	—	—	—	—	2	t-1	—
Total Counties.....	10	3	6	18	6	0	21	31	14	0	11	2	1	15	55	7	70		12
Baltimore City.....	1	0	5	4	5	1	13	10	15	0	7	0	0	33	101	4	519		4
State																			
Sept. 3-30, 1954.....	11	3	11	22	11	1	34	41	29	0	18	2	1	48	156	11	589		16
Same period 1953.....	17	1	9	11	26	2	52	77	58	3	19	3	0	51	161	14	747		38
5-year median.....	15	1	6	—	22	2	37	110		7	23	3	3	62	195	27	697		29
Cumulative totals																			
State																			
Year 1954 to date....	2990	13	296	705	11364	27	2712	86	62	19	1301	15	5	698	1667	133	5746		385
Same period 1953.....	2796	10	1426	396	1489	60	2244	221	180	23	2188	24	9	296	1805	111	6156		574
5-year median.....	3043	23	944	—	4192	44	1531	233		53	885	24	31	462	2113	328	5685		447

m = malaria, contracted outside the U. S. A.

t = tularemia.



Blue Cross - Blue Shield



WHAT PRICE HEALTH?

PAUL D. CARRE*

Everyone you meet, nowadays, knows something about how much it costs to be sick, and most people know that there are numerous voluntary health insurances, non-profit as well as commercial, available to those who want to budget for the hospital and medical expenses they may face.

What progress have we made as a nation during the past twenty years toward protecting ourselves against the unpredictable costs of illness? And what, in fact, are American families doing to meet these costs today? Those of us who provide hospital-medical services or insurance-type benefits naturally have a vital interest in the answers to both of these questions.

The Health Information Foundation, a non-profit organization supported by the pharmaceutical and allied industries, has recently published a preliminary survey based on field work conducted by the National Opinion Research Center during July 1953 covering the twelve prior months. Here, only briefly, is what this comprehensive survey uncovered.

The survey dwelt first upon the actual extent of voluntary health insurance as of July 1953, and came up with the fact that 87 million people, or 57 per cent of the population, were enrolled under some kind of hospital insurance program. People who had protection for surgical and medical expenses numbered about 74 million, or 48 per cent of the population.

Next, the survey broadened its inquiry by breaking these totals down, first to find out who was enrolled, and second, to find out where, economically and geographically, these insured people were concentrated. More people were found to be enrolled in the Northeast and the North Central regions of the country than in the South and the West. By occupation, those employed in "rural" industries had the lowest proportion enrolled, whereas enroll-

ment among people employed in "urban" industries ranged as high as 90 per cent. For one reason or another, the self-employed had the least enrollment anywhere.

By family income, 41 per cent of the families earning less than \$3,000 had some insurance, 71 per cent of the so-called middle income families had coverage, and the highest proportion (roughly 80 per cent) was indicated for families earning more than \$5,000. Altogether, 80 per cent of all insured persons were enrolled through groups.

If this many people had health insurance, what were the expenditures for personal health services and how much did these people spend on insurance premiums or subscription charges? The total annual charges for personal health services during the survey year amounted to \$10.2 billion for all families in the United States. Averaged, these charges came to approximately \$207 per family, including the amount paid out for insurance coverage.

Among all families receiving hospital insurance benefits, half had 89 per cent or more of their gross hospital charges covered. And among the families receiving surgical benefits, half had 75 per cent of their gross surgical charges covered. Altogether, insurance benefits amounted to \$1.5 billion, or 15 per cent of the total expenditures.

Next, the survey considered the utilization of personal health services and, coincidentally, the utilization of voluntary health insurance during the survey year. Generally, the hospital admission rate for all families was 12 per 100 persons per year. People with insurance had a somewhat higher rate (13 per 100) than those without insurance (10 per 100). The average length of stay for all persons hospitalized was 9.7 days, with virtually no difference between those with insurance and those without insurance.

The number of surgical procedures per 100 persons per year for all families was *six*; among insured families the rate was *seven*, and among the uninsured families the rate was *four*. The survey concludes that, as with hospital insurance, surgical insurance tends to increase utilization. The survey points out that for some people at least insurance is the dividing

* Executive Assistant, Maryland Hospital Service, Inc., and Maryland Medical Service, Inc.

line between "must" or emergency surgery and "elective" surgery.

Up to this point, the Health Information Foundation survey centered upon the vital play between hospital and medical costs on the one hand and, on the other, the impact of voluntary health insurance upon these costs and upon the services provided. And although insurance benefits have obviously cut into overall out-of-pocket expenditures, it is apparent from the survey that medical indebtedness still exists.

Among all families in the United States, 15 per cent were believed to have a total debt of \$900

million to hospitals, physicians, dentists and others who render services. In absolute terms, according to the findings, this would mean that roughly 7.5 million families have a medical debt averaging \$121 per family, omitting the secondary debts to individuals and financial institutions.

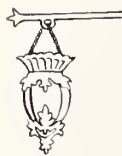
Admittedly, these facts and figures deserve more thorough discussion than this article permits. Many, many factors are involved. And the final report is still being prepared by the Health Information Foundation. But even now, it would seem that these preliminary findings have meaning for those of us in the field.

Annual Meeting 1955

MEDICAL AND CHIRURGICAL FACULTY

*Thursday, Friday, and Saturday
April 21, 22 and 23, 1955*

Ancillary News



PHARMACY SECTION



BASIC FACTS UNDERLYING THE PHYSICIAN'S PRESCRIPTION¹

JOSEPH COHEN, PHAR.D.²

When handed a prescription by your physician, have you ever thought of the many important facts and complex situations which underlie it? Of all the pieces of paper which pass through your hands, perhaps none has a more vital relationship to your physical well being than the physician's prescription. In a sense, it is merely a scrap of paper, but one which plays a highly significant part in your health, and in the health of one-hundred-sixty million people who make up our population.

First of all, what is a prescription? A prescription is a written order for a drug, or drugs, upon which the physician relies for the cure, alleviation, and mitigation of disease. It represents the physician's best judgment after he has made his diagnosis. The prescription represents his mature, professional opinion with respect to treatment, and reflects his view not only of the patient's need, but of all the facts and conditions which form his conclusions as to the drugs to be used, the cautions to be observed, and the conditions to be met.

Physicians write about five hundred million prescriptions a year, which means that more than three prescriptions are written annually for every man, woman and child in our country. This number gives you some idea of the immensity of medical care and of the part the prescription plays in making it effective.

This also means that for five hundred million times a year the medical profession is called upon to

minister unto the sick and ailing and to utilize the prescription as a means toward restoring health.

As you might surmise, the filling of the prescription is by no means a perfunctory matter. Indeed, the law of this state requires that all prescriptions be filled by a registered pharmacist, or by some person acting under his personal or immediate supervision.

The legislature of this State long since recognized the importance of the prescription, and has sought to surround it with every possible safeguard. Among these safeguards are the legal, educational, and experience requirements, which the legislature has written into the State Pharmacy Act, and which every pharmacist must meet before he becomes registered.

The law requires that every pharmacist be a graduate of a college or university which gives a course of four college years in pharmaceutical subjects. The curriculum includes general inorganic chemistry, organic chemistry, biochemistry, theoretical and applied pharmacy, pharmacology, pharmaceutical chemistry, and many other subjects essential to a full understanding of drugs and medicines, and which contribute to making the student a safe and competent pharmacist.

But the state is not satisfied merely to prescribe four years of university or college training in pharmaceutical subjects. It has established an examining board to test the fitness of the pharmacy graduate actually to provide a competent pharmaceutical service. This board conducts written and laboratory examinations in those subjects which the board con-

¹ Maryland Pharmaceutical Association. Radio Broadcast over Station WFBR on Sunday, August 1, 1954.

² Executive Secretary.

siders essential to its purpose. These examinations cover four or five days, and are devoted to practical and searching means of determining that the college graduate is actually qualified for the obligations and responsibilities which underlie safe and competent professional service.

But the conditions which the pharmacist must meet do not end here. Under the terms of the State Pharmacy Act, every pharmacy in this State must have on hand at all times the technical equipment and apparatus which the State Pharmacy Board has declared essential for the filling of prescriptions and the handling of drugs and medicines.

It is worthy of note that in the Maryland State Health Department there is a division of drug control, the function of which is the maintenance of close supervision over retail pharmacies to see to it that the terms of the pharmacy laws are observed, and that the safeguards which the legislature has thrown around the practice of pharmacy are fully recognized and diligently provided.

Indeed, the State has been most careful in its efforts to assure the people of Maryland adequate and competent pharmaceutical service by requiring pharmacists to complete a serious period of study and to give ample evidence of their fitness to assume the duties of a professional pharmacist.

But, what about the drugs which the physician prescribes and which the pharmacist dispenses? This is an interesting question, and opens up a wide vista of professional and scientific interest. We are living in the era of the miracle drugs, and of those other therapeutic agents which have raised medical care to such an exalted position. We are living in an era marked by the conquest of many ancient maladies which, up to a few years ago, defied medical treatment.

We are living in an era, too, marked by profoundly important progress in such diseases as cancer, tuberculosis, diabetes, cardiac disease, and the ills of the aged. Indeed, it would be difficult for those most expertly versed in scientific progress in the cure and treatment of disease to over-estimate the gains which have been made.

The drug industry deserves much credit for the highly gratifying conditions which prevail throughout medical care. To bring this statement into focus, what good would be the discovery of insulin if there had not been an industry capable of producing this life-saving drug in sufficient quantity and at a price

within the reach of everyone? What benefits could have come from penicillin, had not the drug industry expended vast sums for the building of highly specialized equipment from which this product would come in sufficient quantity and at a satisfactory price?

Indeed, the education of the physician and the education of the pharmacist would be largely dissipated so far as its usefulness is concerned were it not for the drug products which the manufacturing drug industry provides. The drug industry is, in every sense of the word, a public health industry, and must be looked upon as an integral part of the medical care team.

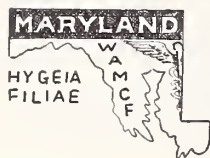
Recent studies have shown that the industry spends more than one hundred million dollars a year on research devoted entirely and exclusively to the discovery of newer and better drugs and medicines, and for the improvement of those long in use.

So efficient and productive has this research been that today, as much as eighty-five per cent of the drugs and medicines prescribed by physicians have become available within the past ten or fifteen years. This is a highly significant statement, because it affords ample proof that the medical profession does not hold onto drugs and medicines when newer and better ones become available. It also shows that the drug industry does not seek to perpetuate old drugs, when newer and better ones come from their scientific research laboratories.

In virtually every one of our large manufacturing plants are to be found extensive research laboratories thoroughly and completely equipped with the most modern scientific apparatus essential to their needs. These laboratories are staffed by scientists of world wide reputation who devote their entire time and energies to the discovery of more effective weapons in the fight against disease.

While the drug industry must be considered as an integral part of the medical care team, it must also be seen as pharmacy on a grand scale, as the complex operations and procedures required in the production of modern drugs and medicines are merely an amplification of those methods and procedures which the pharmacist must employ in the filling of prescriptions and the safe handling of drugs and medicines.

*650 West Lombard Street
Baltimore 1, Maryland*



Woman's Auxiliary Medical and Chirurgical Faculty



MRS. JOHN G. BALL, *Auxiliary Editor*

LIFE IN A GOLDFISH BOWL

ELIZABETH D. WHETSELL

Some of us are wives of specialists, some are wives of general practitioners, some of health officers, some of retired medical men, or perhaps army officers. Some of us have lived in small towns and some in cities. But no matter where we live or in what capacity, we are all doctors' wives, and wives in that respect at least of public servants.

Whether we are retiring and home-loving, or club-minded and extroverts, we are still judged and observed on the basis of being our husbands' wives. It is something rather like living in a goldfish bowl and sometimes very discouraging to realize how prone the public is to pounce on doctors' families for their frailties. Sometimes this realization comes the hard way, when a new doctor's wife may mean everything the right way, with no hidden meaning, no medical interpretations, no confidences betrayed. But it takes a short while to learn that you no longer speak as yourself, casually, but as the doctor's wife, to be quoted, requoted, or *misquoted*, according to the charitability of the quoter!

We must consider ourselves, then, in relation to our husbands' profession rather than just as anybody's wife. We must be careful of our attitudes towards patients and non-patients, others in the profession, and other doctors' wives. There is so much politics and so much self-seeking in *every* walk of life today, so many small-minded people among whom jealousy arises easily. And it is undoubtedly hard for doctors themselves to face, overcome, or ignore some of these attitudes. We, as members of the medical auxiliary, want to help the doctors as a whole, or else we have no excuse for being organized. Should we not then begin by being helpful to our individual doctors? When little things come up to discourage them, when circumstances combine to baffle them as to other people's actions and reactions, it is to us at home that they turn for reassur-

ance. Are we always capable of giving it to them? When their dispositions are worn thin by the stress of "ornery" sick people, are we ready to understand at home that they must use us as escape valves? When they are too tired or too occupied to go out with us socially, as perhaps we have planned, are we able to minimize the disappointment and accept the upset of our plans? Are we big enough to overcome woman's proverbial "catty" tendency (whether that is a deserved proverbiality or not!) and be charitable toward those who cause some of the irritations and upset plans?

Finally, if we know of any doctor who is unethical and grasping, or any doctor's wife who is jealous and grudging of success in others, can we possess our soul in patience while we realize that they are their own worst enemies, and that *right* attitudes and activities *will* triumph in the end?

When national conventions and correspondence, and organized medical groups urge us to talk for our husbands against socialized medicine, I have the feeling that talking is not the only thing for us to do. I believe that *living* our convictions, if we live them steadfastly enough, is the best way to show the non-medical public that our doctors are what the public wants now and that they are always striving further to maintain the *best* relations and give the *best* service to an ailing clientele. When the layman makes an unkind remark about doctors "making money," not knowing how much of their very life-blood goes into the earning of the money, could we not ask ourselves, individually, if we *do* put too much stress on money-making in our family. If we honestly feel that we are not mercenary—and few of us are—then we should simply forget the layman's undeserved remark. Our way of living among our friends and acquaintances will show, better than any arguing words, whether we are as "they say."

All of us can, I'm sure, apply what I have said generally to ourselves in particular instances. And if we are to take a stand against socialized or state-

regulated medicine, I believe the best stand we can take as an organization, is that of a group of right-thinking, right-acting women, who by their example will inspire other people to follow.

AUXILIARY PROGRAM NOTES

Since many Auxiliaries are beginning the year and planning programs, a quick review of the type program we might include in our schedule seems appropriate. Mrs. George Turner, National President, has recommended "Health Service in Communities" as a program starter for this year. Do you know the health services available in your community? Have you helped with any of these services? Are there any new services? What health services are provided by your State Board of Health, local Health Department and School Health Department?

Your State and National Auxiliary will help you plan programs on Nurse Recruitment; Civil Defense; National and State legislation relative to health problems and medical education; the A. M. A., its history, functions and various councils and bureaus; "Today's Health" magazine; the World Medical Association; World Health Organization, and the Student American Medical Association.

For Civil Defense get someone to review Philip Wylie's "Tomorrow" which is excellent recommended reading for all members. It tells the story, dramatically, of the difference between a prepared and unprepared community under an enemy bomb attack. The characters all seem real and have all our very human excuses and lethargy.

Help Pass Along Medicine's P. R. Message!

Four new pamphlets are available, without charge, from the A. M. A., 535 North Dearborn Street, Chicago 10, Illinois:

1. "Quack!" (explains the dangers of consulting quack healers),
2. "Health Today!" (reviews medical progress since 1900),
3. "On Guard!" (explains how the A.M.A. evaluates drugs),
4. "Why Wait?" (tells the best way to select a family doctor).

Use these pamphlets when you have the opportunity at fairs, health forums, schools, public meetings, as mail stuffers, *in doctors' reception rooms*, in reading racks in libraries and hospitals.

A. M. A. Films: Available for TV audiences and for showing on 16 m.m. sound film projectors to clubs, schools, churches, etc.

1. "Operation Herbert"—humorous and instructive film on medical costs today. Approximate time, one-half hour.
2. "A Life to Save"—the necessity of receiving expert medical care. Time, 27 minutes. For TV showing, only until March 1. Write A. M. A. Film Library, 535 North Dearborn Street, Chicago 10, Illinois.

TEN WAYS TO KILL AN AUXILIARY*

1. Don't go to the meetings.
2. If you go, be late.
3. Should you go out of curiosity, make a point of leaving early. This always encourages those who have worked to make a program interesting or a social hour pleasant.
4. If you do attend a meeting, find fault with the work of the officers and members.
5. Never accept office. It is easier to criticize than to do things.
6. Get sore if you are not appointed on committees but if you are, do not attend committee meetings.
7. If asked by the chairman to give your opinion on some matter, tell her you have nothing to say. After the meeting tell everyone how things should be done.
8. Do nothing more than absolutely necessary, but when members use their ability to help matters along, howl that the institution is run by a clique.
9. Hold back your dues, or don't pay at all.
10. Don't bother about getting new members. (sic) "Let Ruth do it."

* Reprinted by courtesy of "The Quarterly Bulletin," Woman's Auxiliary to the Missouri State Medical Association.

Book Reviews*

Peripheral Circulation in Man. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., B. Ch., and Jessie S. Freeman, M.B., B.S., D.P.H., 1954, Little, Brown and Company, Publishers, 219 pages. Illustrated. \$6.00.

A Symposium on "Peripheral Circulation in Man" was given in May 1953 under the sponsorship of the Ciba Foundation, London. This volume contains the excellent papers presented at that time along with discussions of these reports. Much of the information obtainable from this book is not easily available elsewhere and

* The reviews here published have been prepared by competent authorities and do not represent the opinions of any official bodies unless specifically stated.

much previously unpublished work is reported by the discussors.

The various methods available for the measurement of human peripheral blood flow are surveyed. The chapters on the secretion of adrenalin and nor-adrenalin and their effects on blood flow through human skeletal muscle present some newer findings in the pharmaco-physiology of peripheral blood vessels. The effects on circulation following exposure to heat or to cold, the results of sympathectomy, and the possible importance of cold agglutinins are among the numerous problems concerning the peripheral circulation included in this symposium.

E. R. S.

EDITORIAL SURVEY OF REINSURANCE BILL

A. M. A. Secretary's Letter

There was considerable discussion and controversy among some members of the profession relative to the editorials which appeared in the nation's press after the House "killed" the administration's reinsurance bill by an overwhelming majority. To gain a clearer picture of how the newspapers felt about the House action, the A.M.A. Public Relations department made an analysis of the editorial reaction and here, factually, is what it found:

During a three weeks' period, following House action, the A.M.A. received editorials from 65 newspapers which represent 3.5 per cent of the nation's 1,785 daily papers.

Only 15 of the papers, with a total circulation of 2,361,095, were critical of the A.M.A. for its opposition to the reinsurance bill.

Five newspapers, with a total circulation of 301,781, commended the A.M.A. for taking a strong stand against the bill.

Thirty-five of the newspapers, with a combined circulation of 4,746,912, spoke out in favor of the reinsurance bill.

Sixteen papers, with a combined circulation of 817,465, opposed the administration for fostering such a bill.

Fourteen newspapers, with a circulation of 1,173,447, discussed the reinsurance bill, editorially, but remained neutral.

The total circulation of the 65 newspapers, whose editorials on the bill were analyzed by the A.M.A. is 8,774,413 which is only 16.1 per cent of the total national circulation of newspapers.

Coming Meetings

ANESTHESIOLOGY SECTION

CHARLES F. HOBELMAN, M.D., *Chairman*

LIONEL GLASSMAN, M.D., *Secretary*

Tuesday, November 2, 1954, 8:00 p.m.

Deutsches Haus, Room 14, 1212 Cathedral Street

Discussion of the Annual Meeting of the American Society of Anesthesiologists held October 25 to 28, in Cincinnati, Ohio.

OTOLARYNGOLOGICAL SECTION*

ALBERT STEINER, M.D., *Chairman*

WALTER E. LOCH, M.D., *Secretary*

Hopkins Club

Tuesday, November 9, 1954

Dinner Meeting 6:00 p.m.

PEDIATRIC SECTION*

JOSEPH M. CORDI, M.D., *Chairman*

SAMUEL S. GLICK, M.D., *Secretary*

HAROLD E. HARRISON, M.D., *Vice-chairman*

Tuesday, November 9, 1954, 8:30 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Recent Advances in the Knowledge of Disorders of Blood Coagulation. (Illustrated.)

MILTON S. SACKS, M.D.

The Significance and Diagnosis of Systolic Murmurs in Children. (Illustrated.) SIDNEY

SCHERLIS, M.D.

Discussion from the floor following the speakers.

* Section of the Baltimore City Medical Society.

JOINT MEETING RADIOLOGICAL SECTION AND THE CHEST SECTION*

JOHN DECARLO, JR., M.D., *Chairman*
PAUL W. ROMAN, M.D., *Secretary*

JOHN E. MILLER, M.D., *Chairman*
EDMUND G. BEACHMAN, M.D., *Secretary*

Veterans Administration Hospital
The Alameda and Loch Raven Boulevard

Tuesday, November 16, 1954

Film Reading Session 5:30 p.m.

Dinner 6:30 p.m.

Scientific Session 8:00 p.m.

Thoracic Abnormalities Which Occur in General Diseases of the Body. Coleman B. Rabin, M.D., Assistant Clinical Professor of Medicine, College of Physicians and Surgeons, Columbia University.

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty.

RICHARD W. TELINDE, *Chairman*

BEVERLEY C. COMPTON, M.D., *Secretary*

Thursday, November 18, 1954, 5:00 to 6:00 p.m.

1211 Cathedral Street, Baltimore

OPHTHALMOLOGICAL SECTION*

FRED M. REESE, M.D., *Chairman*

HERMAN K. GOLDBERG, M.D., *Secretary*

Hopkins Club

Friday evening, November 19, 1954

Dinner 6:15 p.m.

Meeting 8:00 p.m.

Diagnosis of Intraocular Tumors. WILLIAM F. HUGHES, JR., M.D.

* Sections of the Baltimore City Medical Society

DERMATOLOGY SECTION*

RAYMOND C. V. ROBINSON, M.D., *Chairman* WILLIAM R. BUNDICK, M.D., *Secretary*

Monday, November 22, 1954, 8:30 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Dermatologic Experiences at a Hospital for the Mentally Retarded. (Illustrated.) ISRAEL ZELIGMAN, M.D., AND SAMUEL P. SCALIA, M.D.

Discussion by LEON GINSBURG, M.D.

The Use of Staphylococcus Toxin in Dermatology. HANFORD H. HOPKINS, M.D.

Discussion by HARRY M. ROBINSON, SR., M.D.

Election of Officers to be held.

ORTHOPAEDIC SECTION*

ALLEN F. VOSHELL, M.D., *Chairman*

WILLIAM P. HORTON, M.D., *Secretary*

Monday, November 29, 1954, 8:00 p.m.

Children's Hospital School

Subject to be announced.

THE EASTERN SECTION OF THE AMERICAN TRUDEAU SOCIETY

Sheraton Park Hotel, Washington, D. C.

October 22-23, 1954

Registration 9 a.m., October 22, 1954

Scientific Program to follow.

Invitation is extended to those interested in diseases of the chest, tuberculosis, and cardiology. For additional information contact: Dr. Hugh G. Whitehead, 1201 North Calvert Street, Baltimore 2, Maryland.

* Section of the Baltimore City Medical Society

NATIONAL REHABILITATION ASSOCIATION TO MEET IN BALTIMORE,
OCTOBER 24-27

The annual meeting of the National Rehabilitation Association will be held at the Lord Baltimore Hotel October 24-27. The program on October 25 at 2 p.m. "Maximum Rehabilitation of the Severely Handicapped" will be of particular interest to physicians. This program will be a series of case demonstrations of rehabilitation of the bilateral arm amputee, cord lesion with paraplegia, bilateral leg amputee, paralysis of both legs and one arm, rheumatoid arthritis, and cleft palate and lip. Cases will be discussed by: Dr. Donald Covalt, Physiatrist, Clinical Director, Institute of Physical Medicine and Rehabilitation, New York City; Dr. Robert L. Harding, Plastic Surgeon, and Medical Consultant to the Pennsylvania Bureau of Rehabilitation, Harrisburg, Pennsylvania; Dr. Cloyd S. Harkins, Dental Surgeon, and Director of the Philipsburg Cleft Palate Clinic, Osceola Mills, Pennsylvania; Dr. William Harkins, Dental Surgeon, Associate Director of the Philipsburg Cleft Palate Clinic, Osceola Mills, Pennsylvania; Dr. Roy M. Hoover, Orthopedic Surgeon, and Medical Director of Woodrow Wilson Rehabilitation Center, Fishersville, Virginia.

HIGH BLOOD PRESSURE PROCEEDINGS AVAILABLE THROUGH HEART ASSOCIATION OF MARYLAND

Proceedings of the 1953 Annual Meeting of the Council for High Blood Pressure held by the American Heart Association are now available in a cloth bound, 96 page hard covered monograph through your State Heart Association at \$2.00 per copy. All requests should be directed to the Heart Association of Maryland, 221 E. 25th Street, Baltimore 18, Maryland—Attention: Lee Bowers, Director of Education.

Intended primarily for internists, cardiologists and investigators in the field of hypertension, it includes five scientific reports of original investigative work concerning developments in the field of high blood pressure research.

The brief reports, which deal with relations between endocrine secretions and electrolyte and fluid balance and hypertension, were presented by authorities who summarized their own recent work and the investigations of others in the field. The book compiles in one convenient reference volume material which otherwise is scattered throughout the medical literature.

Contributors to the volume include Dr. R. W. Sevy, of the University of Illinois, who reports on the influences of anterior pituitary gland and the adrenal cortex on experimental hypertension; Dr. Georges M. C. Masson, of the Cleveland Clinic, who reviews an experimental series on the role of renin in experimental hypertension; and Dr. Simon Rodbard, of the Medical Research Institute at Michael Reese Hospital. Dr. Rodbard discusses salt-water balance and body mechanisms in relation to hypertension.

The changing patterns of sodium metabolism in hypertension are described by Dr. D. M. Green, of the University of Southern California. Dr. George Perera of Columbia University reporting on the role of metabolism in essential hypertension, discusses the possibility of a steroid, or steroid relationship, being a basic factor in the disease.

The 1953 Proceedings is the second volume in a projected series. The first volume, the Proceedings of the 1952 meeting, is still available, at a cost of \$1.75, paper bound.

MEETING OF THE SOUTHERN MEDICAL ASSOCIATION

The Southern Medical Association will meet in St. Louis, Missouri, November 8-11, 1954.

POSTGRADUATE COURSES

CARDIOLOGY

A SERIES OF PANEL DISCUSSIONS
OSLER HALL, 1211 CATHEDRAL STREET

Thursday, November 4, 1954, 8:30 p.m.

Myocardial Infarction. Samuel Whitehouse, M.D., Moderator.

Friday, November 12, 1954, 8:30 p.m.

Arrhythmias. E. Cowles Andrus, M.D., Moderator.

Friday, November 19, 1954, 8:30 p.m.

Peripheral Vascular Diseases. George H. Yeager, M.D., Moderator.

Friday, November 26, 1954, 8:30 p.m.

Congenital Heart Disease. Alfred Blalock, M.D., Moderator.

These courses are given under the auspices of the Baltimore City Medical Society, its Sections, and the Maryland Academy of General Practice. A cordial invitation is extended to all members of the Medical and Chirurgical Faculty to attend these courses. There will not be a course in December, but there will be one on "Pediatrics" in January and the information will be published in the December issue of this JOURNAL.

Maryland STATE MEDICAL JOURNAL

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VOLUME 3

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EDITORIAL

THE OFFICERS AND THE BOARD OF GOVERNORS OF THE BALTIMORE COUNTY MEDICAL ASSOCIATION*

The Baltimore County Medical Association is one of the oldest organizations of its kind in the State. It is rich in tradition and active in all phases of medical life.



THOMAS E. WHEELER, M.D., MARTIN E. STROBEL, M.D., AND CLARENCE E. MCWILLIAMS, JR., M.D.

Long a champion of the general practitioner, the Baltimore County Medical Association believes that the general practitioner should assume an ever increasing, active and important place in the affairs of medicine, especially in the activities of the State Medical Society. It believes, further, that the general practitioner is the backbone upon which

* Editorial written by the following: *Officers:* Martin E. Strobel, M.D., *President*; Thomas E. Wheeler, M.D., *Vice-President*; Clarence E. McWilliams, Jr., M.D., *Secretary-Treasurer*; *Board of Governors:* Charles F. O'Donnell, M.D., *Chairman*; Martin E. Strobel, M.D.; Thomas E. Wheeler, M.D.; Clarence E. McWilliams, Jr., M.D.; Melvin B. Davis, M.D.; George F. M. Kieffer, M.D.; William H. F. Warthen, M.D.

our present system of medicine is built. The Association is willing to accept the advice and counsel of the specialist, the full time teacher and the public health official, but it is not willing to be dominated by any special group of them.

In the long and rich history of the Medical and Chirurgical Faculty of Maryland, many physicians from all walks of the profession have given an unselfish hand to help it reach its present eminent position. In recent years, however, feeling has developed that the Medical and Chirurgical Faculty of Maryland has been dominated by physicians from Baltimore City. Whether or not this is true we do not know, but we do know that the counties, whose population of both physicians and people is equal to or greater than the City of Baltimore, have a significant and fundamental part to play in the future. Therefore, we believe that the policies of the Medical and Chirurgical Faculty of Maryland should be directed by the entire membership of the Faculty and not by any branch of specialists or special groups of practitioners, teachers or public health officials.

Only through the counsel and cooperative effort of all of these can the influence and effectiveness of the Medical and Chirurgical Faculty of Maryland continue to grow.

MEDICAL AND CHIRURGICAL FACULTY

ANNUAL MEETING 1955

THURSDAY, FRIDAY, AND SATURDAY, APRIL 21, 22, and 23, 1955

Are you making plans to attend this Meeting? If you live out of the city, have you made your room reservations at the Sheraton-Belvedere Hotel? The Meeting in 1955 will see many new features inaugurated. Plan NOW to come. There will be a round table luncheon on Friday, a dinner meeting on Thursday, and a dance on Friday. Help to make this a successful meeting by attending. Be sure to bring your wife.

Special Articles

THE ORIGIN OF THE BALTIMORE COUNTY MEDICAL ASSOCIATION

MARTIN E. STROBEL, M.D.*

The Baltimore County Medical Association was founded on April 15, 1897.

Dr. Jackson Piper sent an invitation to the physicians of Baltimore County to meet on that date at Grange Hall, Towson, at 2 p.m. for the purpose of forming a County Medical Society. At that time a committee of five was appointed to draft a constitution and by-laws. The constitution and by-laws as drafted by the committee was read, amended, altered and adopted by the Association. This committee also nominated officers who were unanimously elected for one year. The secretary was then instructed to notify every member of the medical profession in Baltimore County of the time and place of the next meeting and invite him to be present.

Dr. George C. Medairy described the following years very colorfully in his autobiography of the Association as follows:

"I was weaned on the frivolity of the "gay nineties;" beheld the dawn of a new century and had just fallen into the prevailing pattern of indifference and complacency, born of a grandiose materialism, when I was rudely awakened by the sinister specter of the first world war. Shocked into a sober consideration and evaluation of the meaning of human and spiritual values, I relaxed but reviewed with apprehension the increase of lawlessness, crime and delinquency during the "roaring twenties;" I staggered under the economic depression of the "thirties," from which I was slowly recovering only to be confronted with the dreadful curse of the Second World conflict of the "forties" in which I again took active participation; and I am now approaching the half-century mark in fear and trepidation standing on the brink of world chaos."

From that small group of far sighted physicians the membership in our Association has gradually grown to 238.

For fifty-eight years the Baltimore County Medical Association has been ever mindful of its objectives to promote the diffusion of knowledge and the cultivation of friendly relations to the end that the profession may receive that respect and support within its own ranks and from the community to which it is entitled.

*59 Hanover Road
Reisterstown, Maryland*

* President, Baltimore County Medical Association.



HISTORY OF THE SEAL OF THE BALTIMORE COUNTY MEDICAL ASSOCIATION

WILLIAM A. PILLSBURY, M.D.*

In 1952, the Baltimore County Medical Association was desirous of obtaining a suitable and original seal, and accordingly a contest was planned among the students of the Baltimore County Secondary schools. The purpose of this contest was threefold: (1) to establish better public relations between county physicians and the county residents; (2) to foster good will between the family doctor and his patients through a common medium, the county high schools; (3) to search out artistic talent among the students.

This contest was approved by the County Board of Education and had the full support of the art departments. Three distinguished judges were selected. Prior to the judging the entries were exhibited at the Towson Health Center. The response to the contest was enthusiastic and many entries were received.

The winning entry, which is now the official seal of the Association, was submitted by a senior student at the Catonsville High School, Lee Einwaechter, who won the first prize of a \$50 Defense Bond. This entry featured the date of founding of the Association along with a geographical outline of the county plus a medical symbol. The prize was awarded at a luncheon meeting at the Maryland Institute of Art, and the event was well publicized. Thus the Baltimore County Medical Association seal was obtained in a manner which benefitted the association with good will as well as an excellent seal.

Timonium, Maryland

* Journal Representative.

THE GOLDEN HEADED CANE OF THE BALTIMORE COUNTY MEDICAL ASSOCIATION

MARTIN E. STROBEL, M.D.*

The badge of authority of the President of the Baltimore County Medical Association is an ebony cane with a beautiful, engraved, golden head which is inscribed with the names of the past Presidents and the dates they held office.

The Golden Headed Cane has become a treasured emblem and has been handed from each retiring President to his successor since it was donated to the Society by the late Dr. George H. Hocking. Dr. Hocking presented the cane to Dr. John S. Green, Jr., of

* President, Baltimore County Medical Association.



DR. CHARLES F. O'DONNELL PRESENTING THE GOLDEN HEADED CANE TO DR. MARTIN E. STROBEL

Towson, at a special meeting of the association which was held at the bedside of Dr. Hocking. Dr. Green passed the cane on to Dr. William H. F. Warthen his successor as President.

Dr. Warthen made the first formal presentation as part of his oration as retiring President. His sentiments are so well expressed that I feel the last paragraph of his address should be quoted in its entirety.

"And now it is my rare privilege to perform a ceremony which is new to the Association but which will become a hallowed tradition in the future annals of our great Baltimore County Medical Association. I address you, Mr. President. I hand to you the Golden Headed Cane of the Baltimore County Medical Association. I hand it to you in loving memory of Dr. George H. Hocking our late confrere, who thought so much of the Association through the years that he parted with one of his dearest worldly possessions. By his unselfishness and devotion Dr. Hocking through this gift has shown us a symbol of that for which we all strive—to earn the wholesome respect from all who seek our aid and whom we seek to aid by giving all that we have to our great love, medicine. Treat this our own Golden Headed Cane fondly, tenderly, lovingly and let it continue to be a symbol and example of unselfishness and a life devoted to service as Dr. Hocking would have you do."

*59 Hanover Road
Reisterstown, Maryland*

Health Department Articles

THE COOPERATIVE PUBLIC HEALTH PROGRAM

WILLIAM H. F. WARTHEN, M.D., M.P.H.*

The rapid growth of Baltimore County in terms of population in the past several years, during World War II and subsequently has become well known to the people of Maryland. Of equal magnitude and significance is the reputation the County has gained as an attractive and satisfying home area for the suburban minded and as a community with compelling appeal to those who seek the economic opportunities of industry and commerce. These factors have been operating continually and the concomitant result has been the demand by the citizens and the medical and allied professions for a more improved program of preventive services to all who live in Baltimore County.

The problem for the Health Officer and his staff has not always been one of setting up controls for new and unusual diseases. Rather the problem has been one of dealing, by detection and prevention, with diseases and deviations from the normal which are already indigenous to the communities within his jurisdiction. The diseases and deviations from the normal vary in direct proportion to the increase in the size and character of the population received into the county (1). The Health Officer's task has been, and still is, to bring his already existing program of health activities into line with individuals and agencies whose efforts may be related to health, and to direct the emphasis of the several parts of his organization into the most productive channels for many county communities, swollen almost to the bursting point. He is confronted many times in a suddenly and tremendously enlarging community, with the

uphill job, and none-too-encouraging result, of trying to enlarge his staff sufficiently to meet the expanding field of needed health activities. Nor is a full complement of staff and equipment the true ideal or the answer to all of his problems although the following developments have had a prime bearing upon the effectiveness in modernizing the health program in Baltimore County from 1940 through 1954: (1) the total number of full time workers in the Baltimore County Health Department has increased from 17 to 95; (2) the annual official budget amounts granted have increased from \$30,528.71 to \$564,877.62; and (3) the annual per capita expenditures from official sources for the health program has risen from \$.19 per person to \$1.77 per person.

It is the purpose of this paper to point out and to describe briefly a factor that is of the highest rank in the development of a sound and workable health program that gives the most for the money and effort expended by all those who, both professional and non-professional, can, should, and do participate in formulating and carrying out the program in Baltimore County. This health program is cooperative in its broadest sense and best meaning and typifies a jointness of interested, diligent and advised effort equally on the part of the medical, allied professional and health agencies on the one hand and the Health Department on the other. Since physician-health department relationship will undoubtedly be of particular interest to the members of the Medical and Chirurgical Faculty of Maryland, the descriptive emphasis in this article will be placed upon this all important and essential

* Health Officer of Baltimore County.



Towson Health Center in Headquarters Office of Baltimore County Health Department

phase of what we have deemed to be a good community health program in action.

Organization of Advisory Groups. The Baltimore County Health Department has for a number of years adhered strongly to the thesis of developing and continuing an over-all council of key professional and lay individuals who serve as advisors to the Health Officer in his plans for the local health program. The selection of the personnel by the Health Officer, the structure and organization of a council and the frequency and content of meetings of such a group should, we believe, be approached and activated in a most thoughtful and painstaking way. This has been done in Baltimore County and it may be pertinent to point out in some detail how this general advisory council to the Health Department was formed and by so doing to encourage the reader

to judge as to what degree the original far-reaching objectives of the council have been fulfilled (2).

THE ROLE OF THE PRIVATE PHYSICIAN IN PLANNING

The health council of Baltimore County is divided into two sections. The first, designated as the BALTIMORE COUNTY COMMITTEE ON MEDICAL CARE, was established in 1945 to advise the Health Officer concerning the interpretation of State Health Department policies and procedures and their (3) application in Baltimore County and was later enlarged to include the public health program in general with the exception of school health services (see below). The membership of this committee includes the following individuals and agency

representatives: (1) two members of the Board of Health of Baltimore County; (2) the President of the Baltimore County Medical Association and four physician members of the Association; (3) three members, of whom one each is designated by the dental, by the nursing, and by the pharmaceutical professions; (4) one member designated by the Baltimore County Public Health Association, the voluntary health agency of the County; (5) the Superintendent of the Board of Education of Baltimore County; (6) the Director of the Baltimore County Welfare Board; the Director of the Children's Aid and Family Service Society of Baltimore County, and the Director of the Associated Catholic Charities of Baltimore; the Health Officer and appropriate members of the staff of the Health Department and, by invitation, appropriate members of the State Department of Health.

It is to be noted that the Baltimore County Medical Association is officially represented in this section of the Council. As is true of all the agencies he approaches to be included in the Council, the Health Officer requests the Baltimore County Medical Association to name physicians from different areas of the County together with the current President of the Association to serve as active members of the BALTIMORE COUNTY COMMITTEE ON MEDICAL CARE (4).

The second division of the Council is what has come to be known as the SCHOOL HEALTH COUNCIL which was organized in 1946 at a time when the Health Department began to expand and to intensify its school health services in the public and Catholic elementary schools in Baltimore County. The membership of the SCHOOL HEALTH COUNCIL consists of the following: (1) the Superintendent of the Board of Education and the Health Officer of Baltimore County, serving as cochairmen; (2) the Superintendent of Catholic Schools; (3) one physician member representing the Baltimore County Medical Association and one dentist representing the local dental profession; (4) delegates from

the County-wide Parent-Teacher Associations; (5) a principal and a teacher; (6) two members of the Baltimore County Public Health Association; and (7) appropriate members of the staff of the Baltimore County Health Department and, by invitation, appropriate members of the State Department of Health, of the State Board of Education and of the County Board of Education.

Note that here again in this section of the council the membership includes a representative from the Baltimore County Medical Association. The manner of appointment of the physician to the membership of the SCHOOL HEALTH COUNCIL follows the same pattern as that of the medical care committee.

The medical care committee meets regularly four times and the school health council at least two times each year and the two sections may meet together as a HEALTH COUNCIL when there are public health areas of mutual interest to be considered. The tremendous importance of these periodic advisory group meetings, singly by sections or as a whole, lies in the valued suggestions given to the Health Officer and his staff, suggestions crystallized after free, open, frank and, perhaps just as significant, interested and enthusiastic discussions participated in by every member of the group. It has been found by experience that the two outstanding features as regards the structure and plan of every advisory group meeting have been: (1) brief and well thought-out agenda describing what has happened in the Health Department and the problems upon which the Health Officer would like to have consultative suggestions from the group; and (2) the encouragement by the presiding officers of thorough discussions on each topic presented. By carefully following these two major rules, there have been given to the Health Officer and his staff reasonable plans with recommendations which in the vast majority of instances, when adopted as policies, have made the entire health program of the County highly effective and in many areas of activity, we have

realized, extraordinarily effective. A great many major projects as well as plans for improvement in the already existing Health Department program have been unanimously endorsed by the Baltimore County Medical Association when the content of these plans and projects have been presented as recommended by the medical care and school health advisory groups. Moreover, there is ample evidence to indicate from members of the HEALTH COUNCIL and from key people of the public as a whole that much of the success we have had in our health program is due in large measure to an active council.

COOPERATIVE PLANNING IN ACTION

One may very well ask, "What influence for the good of the health program has this kind of advisory service had upon the structure and function of the Health Department in meeting its legal and educational responsibilities to the public?" We believe that the observer, if he were to review the current activities of the Health Department, would find several strong examples of larger, more efficient and better adjusted preventive services available and distributed to the residents of Baltimore County as a direct result of HEALTH COUNCIL establishment and action. Only a few of the activities of the Health Department can be briefed here (5), but from the resumes which follow one may see the thread of daily interaction and interdependence between the Health Department and its valued professional allies on the one hand, and the people in the many "communities within the community" of Baltimore County on the other.

The Program in General. The Baltimore County Health Department is a large local public health unit authorized and supported jointly by the Maryland State Board of Health and the Board of Health of Baltimore County (County Commissioners of Baltimore County). Under the direction of a full time Health Officer there are 95 full time employees who by education and experience are especially qualified to carry out a County-wide program of preventive medicine.

The Health Officer has as his assistants four physicians, a dentist, a public health nurse, a sanitary engineer and a social worker. The larger divisions of medical activities within the Department, headed by these assistants, are the acute communicable diseases, venereal diseases, cancer control, child health services including school health services in which conservation of hearing is an integral part of the program, dental health, and mental health.

The major non-medical group within the Health Department is the Division of Environmental Health. The program of this division is directed by a sanitary engineer, and consists of inspections of all types of insanitary conditions, private water supplies, bathing beaches, camps, boarding homes, hospitals and day nurseries. The daily work of the division is focused upon those physical and environmental factors which may have a bearing upon the health of individuals, families, and groups of individuals who may be concerned. There are more than 1,700 foodhandling establishments which are regularly inspected, and there are several dairies located in Baltimore County which prepare milk for sale locally which are kept under the surveillance of the Health Department.

Of the 95 full time individuals employed by the Health Department, 54 are public health nurses who carry on a generalized public health nursing program. These public health nurses render daily service in connection with all the activities of the Health Department.

Medical Care. This program is founded upon the following basic principles, some explicit and others implicit in the law, and regulations: (1) the program is financed in Baltimore County by State and local funds with no Federal aid or intervention; (2) it is in unison and in harmony with the prevailing method of medical practice in the counties, namely, a fee-for-service system in which the general practitioner is the key figure; (3) it is administered jointly by the State and County Departments of Health; (4) it is designed to take care of the medical needs of those who

are normally self-supporting, but who cannot pay the cost of illness; (5) it is dedicated to the free choice of physician, and other professional personnel, by the patient, as well as to the professional participant's right to accept or refuse patients as he desires (6).

The program provides the following services: (1) physician's services in the home, office and nursing home, and delivery in the home and consultant services may be available; (2) drugs to the patient certified as prescribed or dispensed by the physician, with very few limitations in the way of experimental drugs; (3) dental services, including fillings, extractions, x-ray, fluoride therapy, dentures on a limited basis; and (4) special diagnostic services, beyond the scope of the physician's office, in hospital outpatient departments.

Two groups of individuals are eligible for services in the program: (1) all recipients of public assistance who are automatically eligible; (2) any person who believes himself to be unable to pay for medical care who may apply to the Health Department in the county of his residence. In the latter classification, eligibility is determined upon the basis of objective standards of income and resources and, in exceptional cases, upon the Health Officer's judgment concerning medical and social needs. All eligible patients are identified by special cards issued by the Health Department.

The Baltimore County Health Department is probably one of a limited number of local health departments in the United States which has formalized the awareness of social factors and their effect upon community health to the extent of organizing within the Health Department a Division of Social Service. The program is directed by a medical social work consultant who acts as full time director of the division.

Any licensed physician may participate in the program automatically by submitting bills for any eligible and certified patient. One bill is submitted for each patient seen during a given month. Pay is promptly made by the Maryland

State Department of Health at the end of the month during which services were rendered.

Infant and Preschool Hygiene. These services are designed to prevent diseases and to correct wherever possible physical defects in the child population of Baltimore County through specific activities in maternal and child health. Infant and preschool health clinics are held in the fourteen separate health centers conducted jointly by the Baltimore County Public Health Association and the Baltimore County Health Department. Services of these clinics include immunizations, diagnostic examinations and consultation with local physicians. Many instances of need for further care and medical attention are discovered and, when discovered, are routed to private physicians for further medical care.

Provision for premature infant care is made through the teamwork of the physician who delivers the child in the home, the ambulance services of the official and voluntary fire departments, and the public health nurses. The program is closely related to the premature infant service of the hospitals in Baltimore city.

School Health Services. The school health program is a County-wide health program designed to promote the health of the children of Baltimore County by bringing increased health services to the school-aged child through the preventive medical services of the Baltimore County Health Department and the teaching services of the Board of Education of Baltimore County and of the Department of Catholic Education working together as a unit in health. The plan has as its primary purpose the improvement of the physical and emotional well-being of the children of the County (7). The school health program has three important phases: (1) the prevention and control of communicable diseases; (2) a set of case finding procedures designed to bring to light those children who need medical attention; and (3) a set of follow-up procedures for getting something done about the physical and emotional and social problems which are found. The program is carefully

planned jointly by the Board of Education, the Board of Health and the Department of Catholic Education in the several meetings annually of the School Health Council.

First grade children and referrals in the elementary schools, Catholic and public, receive physical examinations either by their private physicians or by "school physicians." More than 75 per cent of these children are examined by private physicians in their offices and their findings are recorded in the Health Department upon simplified, but at the same time, comprehensive forms suggested originally by the physician member of the School Health Council. The school physicians are practicing physicians who are employed on a part time basis by the Health Department to conduct clinics in the elementary schools where physical examinations have not already been performed by the private physician in his office or in the home. Preschool round-ups are conducted in the elementary schools at the spring County-wide school registrations for new pupils, and in the round-up in each school teacher-nurse-parent conferences are conducted. These conferences are valuable in uncovering physical and emotional needs of the preschool child so that they may be corrected if possible during the summer months before the school starts in the fall. Letters are sent to all practicing physicians in the County requesting their recommendations upon the health of the individual child of school age under their care—a feature discussed at the School Health Council in which the physician member played an active part.

The Massachusetts Vision Testing program is made available to all elementary and secondary schools, both public and Catholic, in Baltimore County. This program provides for the screening of all school children for visual defects. Parents of those children found with visual defects are notified by letter and asked to consult their private physician regarding the need for further examination and treatment.

The conservation of hearing program makes

available an audiometrist for the purpose of screening all third grade children in the elementary schools in the County. Letters are sent to the parents of these children advising that they consult with their private physician regarding the need for further medical care.

An active and timely control and health education program is conducted in the elementary schools in connection with the communicable diseases. The Health Department is constantly endeavoring to institute measures to control the acute communicable diseases of childhood as well as the infestation of scabies, pediculosis and ringworm. Public health nurses are continually screening by inspection suspected cases of ringworm of the scalp, and the education of local barbers is part of this program.

An important advance in health education was made in 1954 with the publication each week of the *Health Bulletin*. This publication of two mimeographed sheets gives a concise statement of the current occurrence of communicable diseases and includes information relative to the control of these diseases as well as other items of timely interest upon good health habits. The latter item in the bulletin is of vital and equal interest to parents, principals, teachers, public health nurses and private physicians and the mailing list includes all of these groups. This publication has received perhaps more favorable comment, since it was inaugurated just a few months ago, than any in recent years. The idea was first mentioned by a private physician in Baltimore County at one of the meetings of the Baltimore County Medical Association.

Tuberculosis control in the schools is a well organized program under the Director of the Division of Tuberculosis of the Department, and includes the x-raying each and every year of all adult employed personnel of the schools. Cases found positive on x-ray screening or on large plates are referred confidentially to their private physician for consultation and treatment by him or a specialist or agency he may recommend.

Surveys of Children's Institutions in Baltimore County. Following medical surveys of the two large correctional institutions for children located in Baltimore County, a continuing medical and health consultation service was inaugurated and has been maintained first, at the Montrose School for Girls and second, at the Maryland Training School for Boys. Extensive surveys had been made by the staff of the Baltimore County Health Department and consultants from the Maryland State Department of Health following a request first from the Board of Managers of each of these children's institutions and then from the Director of the State Department of Public Welfare. The physician in charge of each of the institutions served actively on the survey study (8) (9).

The Prevention of Tuberculosis. The Division of Tuberculosis is responsible for the administration of those Health Department services having to do with the detection, diagnosis and treatment of tuberculosis cases and for the prevention of further spread of the disease. To carry out such a program the fundamental activity is that of case finding. After this is accomplished the objective is for early diagnosis and adequate clinical management prior to hospital admission and following discharge from the hospital. Following diagnosis of an active case of tuberculosis every effort is made to prevent further spread of this disease to susceptible individuals. The methods used to accomplish this are the following: (1) chest clinics operated at twelve health centers staffed by competent clinicians; (2) "x-ray only" clinics held in eight health centers; (3) mass x-ray surveys scheduled annually among industries, schools, communities, institutions; and (4) epidemiological tracing and investigation of contacts.

In carrying out these activities, the public health nurses are responsible for educational programs in the home, the school and the community. The nurse also organizes and manages the chest clinics and "x-ray only" clinics. She works in the field finding and tracing contacts

and referring suspected cases of tuberculosis to private physicians and Health Department clinics. The nurse visits the home, teaching the care of tuberculosis patients and the prevention of spread and she assists the family and the patient to prepare for his return following hospitalization.

An assistant health officer, the Director of the Division of Tuberculosis, is responsible for the medical supervision of the services of tuberculosis control. She receives reports and consults with private physicians before referring positive cases to him or to a clinic, if he desires, for treatment. There is maintained an index file and pertinent statistics on cases cared for by private physicians, hospitals, and clinics. The maintenance of such a file and its daily use is recognized by tuberculosis control authorities as a *sine qua non* of an alert official health agency.

Daily Health Department Service to Public and Physicians. Responding to the demands of increased and continuous round-the-clock health services to public and physicians, the Health Department inaugurated early in 1953 a Saturday, Sunday and holiday consultation and biological distribution service. A Health Department staff member can be reached for this service by telephone through the regular Department switchboard on all these days when business offices in general are closed.

CONCLUSION

The experiences of the Health Officer of Baltimore County tend to show very clearly that: (1) the effort expended upon organizing with care and diligence advisory professional and non-professional groups is one of the most worthwhile preoccupations of a health officer; (2) advisory groups can and do, by their existence and through a cultivation of their talents, form the nucleus for active and integrated participation of all groups throughout the community who are interested in the health program; (3) the structure and functions of the Baltimore County Health Department program reflect the con-

sidered opinions and recommendations of advisory groups; and (4) advisory groups can enhance immeasurably the tone and character of the health program without usurping the legally established prerogatives of a health department.

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A LOOK AT SOME OF THE FEATURES OF THE HEALTH AGENCY IN BALTIMORE COUNTY

MELVIN B. DAVIS, M.D.* AND CHARLES F. O'DONNELL, M.D.*

Physicians are interested and concerned in the prevention of disease within their communities. They always stand ready to help the official health agency in its efforts to carry out a County-wide health program. To solve the problem of bringing a knowledge of the prevention of disease or the restoration of health to everyone in the community, the program can reach a high mark of sufficiency only when physicians and others in the community take an active part in its planning and execution. Any health department accrues better results from its public health work when the practicing physician is well informed of the principles of preventive medicine. He also must have an understanding of how the health department is applying these principles in its

everyday activities. This is true for every physician, whether a specific patient and a specific disease are the problems of the moment or whether the problem is one of bringing to the members of the family he sees, and others, this important matter of ways to maintain health. He will be the better practitioner with greater personal satisfaction who teaches prevention. By the same token, he will be the more effective health officer who will grasp every opportunity to get the views of individual practitioners as regards the health program and to create a time and place for these views to be expressed, not alone to himself but to his advisory groups as well.

A health department can never hope to carry out a program of health education in the com-

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munity without the active assistance of the physicians. It is they who, in the course of their diagnostic and curative work, have more occasions than the health department and its staff to state and to enlarge upon the meaning of the most important things for individuals to do to prevent the spread of disease and to attain the maximum in health. In his contacts with individuals and families, there ensues a professional satisfaction when he feels sure that his approach and general method of presenting facts corresponds to that of his health department.

In the complexities of providing for the community a curative and preventive program, many members of the medical and allied professions must sacrifice their time for conferences with the health officer and his advisory groups. The astute health officer appreciates the magnitude of the sacrifice made by the practicing physician and others interested in community health. They are busy people indeed and must be given top priority in his departmental conferences. When such conferences are well organized, and when the agenda are to the point, and when thought has been given beforehand to a specific problem or problems, much can be accomplished. In a relatively short period of time the resolving of difficulties that may present themselves and the arriving at a workable procedure which can guide the practitioner to do his part and the health agency to do its part will result. Of course, there must be a sincere willingness on the part of the Health Officer to be open-minded, to entertain for consideration any and every suggestion and, in an unprejudiced manner, to abandon outmoded and to adopt new ways of operation. He must exercise a determination to execute promptly, constantly and conscientiously the set of procedures he and his groups have decided upon after all phases of the problem have been thoroughly thrashed out.

There are two sets of currently operating procedures in the Baltimore County Health Department. In both of these private physicians

and others concerned in the community have participated. The form and content of these procedures illustrate the thoroughness of the discussions of the advisory groups and their acceptability to the medical profession. When presented to the Baltimore County Medical Association, the recommendations were understandable and promptly endorsed. There are many other such mutual projects undertaken by the physicians and Health Officer in Baltimore County which could be cited. However, in the interest of brevity, the following are enlarged upon here: (1) tuberculosis procedures; and (2) conservation of hearing procedures.

HEALTH DEPARTMENT TUBERCULOSIS PROCEDURES

The improved plan of mutual assistance by the Health Department and private physicians in the matter of tuberculosis detection and control has been in effect in Baltimore County for nearly two years. The results have been excellent by way of better finding of cases, prompter treatment by the physician, and a more intensive following of contacts in the prevention of the spread of the disease. In a circular letter issued in July of 1952 to the physicians of Baltimore County from the Health Officer (1) it was stated: "An important change in the procedure of the Baltimore County Health Department chest clinics will be effective August 1, 1952. This plan has evolved from careful consideration of various difficulties which have existed, and represents the cooperative effort of the Executive Committee of the Baltimore County Medical Association, the Bureau of Tuberculosis of the Maryland State Department of Health, the Baltimore County Public Health Association and the Baltimore County Health Department." The new procedure was outlined as follows:

1. Patients reported to clinics will be x-rayed, and the patient's sputum will be collected where indicated and when it is obtainable. No other initial studies will be done unless

specifically requested by the referring physician.

2. A report of the x-ray findings, interpretation, and recommendations will be sent to the referring physician from the clinic.
3. Accompanying the report will be a card which is to be returned to the clinic as promptly as possible. The physician will check this card to indicate: (a) if he will assume all follow-up of the patient; (b) if he wishes any Health Department services; or (c) if he wishes the Health Department to assume all follow-up of the patient.
4. In those cases in which the physician wishes to refer a patient to a particular chest clinic for assuming all follow-up of the patient, it is extremely important that the physician give to the patient referred a written request for such services so that the patient may present this request at the clinic.
5. It has been agreed upon both by the Executive Committee of the Baltimore County Medical Association and the Baltimore County Health Department that investigations in the homes will continue to be made to find contacts of known cases and these contacts will be followed to determine any evidence of tuberculous infection. Any positive cases found among contacts will be referred to their private physician.
6. In the case of patients on medical care, they will as is required by law, be given complete clinic services; but a full report of all findings will be sent to the physician to whom they would go in the event of acute illness, so that he may be informed as to their tuberculous status.
7. When a patient does not have a physician at the time of his x-ray, he will be supplied with a list of all physicians in the clinic area and asked to designate one.

From the above it is evident that the plan of control of tuberculosis in Baltimore County is intended to accomplish two fundamental ob-

jectives through the cooperation of the private physicians of the County with the Health Department: (1) the prompt referral of cases of tuberculosis to physicians for their decision as to their treatment; (2) very much greater opportunity for the Health Department to intensify its program of finding new cases of tuberculosis by using State mobile x-ray units for the taking of small plates, in the schools, in the industrial plants, and in the many communities within the County (2). In the schools an especially adapted method is employed. All adult personnel employed by the Board of Education of Baltimore County have been x-ray screened for pulmonary tuberculosis or have presented themselves to their private physician each year beginning in 1951. All finally checked positive results have been brought, in a most confidential manner, to the attention of the Health Department, the individual concerned, the Board of Education and the private physician. This has produced a greater interest by the private physician in detecting the early case of tuberculosis in his own practice by: (1) taking x-rays himself; (2) referring the case and possible contacts to the clinics of the Health Department. He finds it easier to report the case or suspicious case promptly and to receive consultation from the Health Department staff. The best result of all has been that private physicians and the Health Department are working quite happily and harmoniously together toward a most important goal which we all hope will not be too far away—the eradication of tuberculosis.

Physicians and health agencies other than our own in Baltimore County have observed the success of this plan of tuberculosis control. The Committee on Tuberculosis of the Medical and Chirurgical Faculty of Maryland, after careful study, recommended to the House of Delegates at the 1954 Annual Meeting that the Baltimore County Plan for Tuberculosis Control be adopted by all the counties of Maryland and Baltimore City. The recommendation was unanimously approved by the House of Delegates.

CONSERVATION OF HEARING

A program directed primarily at the prevention of deafness among children has been in operation in Baltimore County since 1949. This program has shown many improvements since its beginning. These improvements have been in the nature of increasing the interest of the private physician in this very important phase of health conservation and rehabilitation. Here again, from Health Department conferences to draft exact plans in which the private physician had a prominent place, a set of suitable procedures was developed and endorsed by the Baltimore County Medical Association, and placed in effect. These Health Department procedures, which have proved their success for more than two years, give the parent every encouragement to seek the private physician's advice and every opportunity for the physician to give the needed preventive service. The plan can be summarized by abstracting here the essential paragraphs of a letter, dated May 13, 1952 (3) from the Health Officer to the private physicians of Baltimore County:

"By the end of the present school year all children in the third grade in public and Catholic schools will have been tested in the schools by the Health Department's audiometrist. Beginning in May of this year the parents of those children still to be tested and those to be tested in subsequent school years, will be notified by letter from the principal of the school of the results of a hearing test made by the audiometrist. Included with this notification to the parent is a letter to the private physician requesting his recommendation.

"As you probably know the Health Department conducts at the Towson Health Center a conservation of hearing clinic, where the causes of hearing loss are determined by a nose and throat examination and treatment by radium is available. Children may be referred here by private physicians. The bottom of the letter to the

private physician, referred to in the paragraph above, can be used for this purpose, but if more convenient, the physician may telephone the Health Department or write the secretary of the conservation of hearing program in the Health Department in order to refer a case. A full report on the physical findings will, of course, be made in a letter to the physician when a case is referred to this clinic.

"The early prevention of possible continuing hearing loss is, I am sure you will agree with me, highly important not only in the school-aged child, but also in the pre-school child. Therefore, if there are any further ways the Health Department may be of service to you and to the children of Baltimore County, I hope you will let me know. Please call me if I can explain or clarify this new procedure."

SUMMARY

There are presented above two examples of the interest private physicians have in preventive medicine and in their health agency. In accomplishing this desirable end in Baltimore County, it has been essential that private physicians, Health Department and voluntary health agencies lend their faculties diligently, tirelessly and selflessly to work together for the health of the community. This has been done in Baltimore County to the credit and good repute of the private physicians, the official and voluntary health agencies and others. The patience and perseverance the Health Officer of Baltimore County has given in the formulation of these workable procedures is recognized as an appreciable service to the physicians and through them, to the people of Baltimore County.

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TUBERCULOSIS AND ITS PREVENTION IN BALTIMORE COUNTY

MARGARET LEE SHERRARD, M.D.*

The death rate from tuberculosis in Baltimore County has shown a marked decline over the past few years. This parallels the nation-wide decrease in mortality rate from the disease that was once a "major killer." The national tuberculosis death rate of more than 200 at the turn of the century had decreased and approximated 12.5 per 100,000 population in 1953 (1). In Baltimore County the mortality from tuberculosis has declined phenomenally from 43.2 in 1940 to the new all time low of 8.5 per 100,000 population in 1953 (2).

This downward trend cannot be attributed entirely to the recent developments in drug therapy and new surgical techniques. The change began before that. Ample evidence tends to indicate that it is more likely to be the result of a general health movement which began in the nineteenth century (3). Later the campaign to combat the spread of this specific disease was widely developed by local, state, and national agencies aided by anti-tuberculosis associations and private beneficence (4). Much publicity has been given to the curability of the disease and the necessity for early diagnosis and treatment. As a result of this publicity there has been better understanding of the disease and its treatment and attempts have been made to establish the necessary facilities.

In Baltimore County, the fight for the past

fourteen years against tuberculosis has been a cooperative one, an objective that has been foremost in the plans of Dr. William H. F. Warthen, the Health Officer of Baltimore County (2). The private physician, the official local and state agencies, the voluntary associations, and individual volunteers unite in their efforts to eradicate tuberculosis. The Baltimore County Health Department carries on an organized control program in the detection of cases and in the prevention of spread of the disease. The Division of Tuberculosis keeps an up-to-date file on all diagnosed cases. Chest clinics and "x-ray only" clinics are operated regularly throughout the County. Mass x-rays surveys are scheduled annually among industries, schools, colleges, institutions, and communities. The Division of Public Health Nursing cooperates, assists and functions effectively in carrying out at all times this program of prevention, in the home, in the school, and in the clinic. The Baltimore County Health Department obtains valuable assistance from the Baltimore County Public Health Association, through its Tuberculosis Committee, and works closely with the Baltimore County Medical Association (5).

Case finding is one of the chief activities in the control of tuberculosis. Each case of tuberculosis diagnosed by private physicians or any agency in the County is reported to the Division of Tuberculosis. A master card file with summarized significant clinical and environmental

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data is maintained on every reported case. New cases are also diagnosed in chest and "x-ray only" clinics operated by the Health Department and data likewise entered on cards in this file which is checked daily for accuracy.

The clinics of the Health Department do not compete with the private practice of medicine. On the other hand, both the chest and "x-ray only" clinics are designed, by purpose and function, to take care of those patients who cannot afford a private physician, or who do not have a private physician. The clinics serve as a starting point where advice and services are extended to the physician for his patient if he so desires them (6).

On his first visit to the clinic the patient is x-rayed and sputum is collected if indicated. A report of the x-ray findings, the diagnosis and recommendations are then sent to the referring physician. If the patient has no physician, he is asked to designate one. The Health Department will continue to follow the patient if the referring physician requests this. At times the private physician follows the patient entirely or may request x-ray services and sputum examination as needed. As agreed upon by the Baltimore County Medical Association and the Baltimore County Health Department, it becomes the responsibility of the Health Department to follow the contacts of all diagnosed cases of tuberculosis. A report of these examinations is sent to the private physician along with any positive diagnoses (7). Competent clinicians with specialized training in tuberculosis head the chest clinics and are willing to consult with the referring physician concerning his particular patient. In order to keep in contact with individuals with tuberculosis who are being followed by private physicians, the Division of Tuberculosis writes the physician requesting pertinent information. In this way an up-to-date file may be maintained.

After an individual has been diagnosed as having active tuberculosis, he may require hospitalization. Applications are made through

the private physician or the clinic physician to the State Department of Health which carries on the operation of the State Tuberculosis Hospitals. With the newer concepts in the treatment of tuberculosis, which have resulted from advances in the knowledge of chemotherapy and from newer methods in anesthesia and in surgery, there is a trend toward shorter periods of hospitalization or no hospitalization at all (8). However, it should be kept in mind that even though chemotherapy is bringing relatively rapid improvement in the patient's condition, it has not been definitely ascertained that these drugs assure permanent cure. Long term evaluation of the results must be made (9).

Although the tuberculosis mortality rate has declined and there have been rapid advances in the method of treatment, the Health Department should never relax in its efforts to find new cases. Only then can efforts be made to prevent the spread of infection from this all important source. In the days when the diagnosis of a case depended upon the classical picture of such cardinal signs and symptoms as weight loss, cough, and hemoptysis the results from treatment were poor. On the other hand, x-ray affords one of the foremost methods of early diagnosis, when symptoms are often absent. Experience shows that a higher percentage yield of positive cases come from particular segments of the population such as household contacts. However, a great number of active cases would be missed if x-rays were not made on massive segments of the population. This activity is carried on by mass x-ray surveys (10). Once a suspicious x-ray is found on a 70 mm. film every effort is made to obtain a definite diagnosis by large film.

Despite the progress made against tuberculosis, the fight is not yet over. The incidence rate in Baltimore County is still 58.2 per 100,000 population (1953) even though the corresponding rate for 1940 was as great as 88.2.

This striking editorial appeared in *The Evening Sun* of January 22, 1945.*

* Reprinted by courtesy of *The Evening Sun*.

"ALERTNESS IN THE COUNTY

"Much of Baltimore County is so closely meshed with Baltimore city that in such a matter as the protection of public health each is dependent upon the other's efficiency. Indifference to or ineffectiveness in sanitation or the control of communicable diseases on either side of a political boundary that runs through what is in fact a single community would expose the whole population to serious danger. If, therefore, Baltimore County can take comfort in the fact that the Baltimore City Health Department is a capable and effective agency, Baltimore City can find equal gratification in a Baltimore County Health Department that rates high in competence.

"In recent years, under the direction of Dr. W. H. F. Warthen, County Health Officer, the Baltimore County Health Department has been expanded and departmentalized in conformity with modern standards. Clinical services have been multiplied, the cooperation of practicing physicians in the detection and reporting of communicable diseases has been gained and techniques suitable to the urban conditions that now characterize much County territory have been adopted. Dr. Warthen is not a stranger to the health problems of congested communities. He went to his county post from the assistant directorship of the Baltimore City Health Department.

"It is reasonable to believe that this greater activity of the County Health Department, rather than an upsurge in incidence of the disease, accounts for most of a sharp increase in new cases of tuberculosis reported for the county last year. If so, the increase is good news rather than bad. It means that 450 cases, this being the number reported, instead of the average 150, are under treatment and the dangers of communication lessened. One of the difficulties that confront control of tuberculosis is the undetected sufferer and carrier. This is equally true in the case of venereal diseases and, indeed, all contagions. It is good to know that Baltimore city's immediate neighbor is on the alert against these enemies of individual and public health."

There are two cardinal facts which have a significant bearing upon the road ahead to the decrease in tuberculosis we hope for in Baltimore County. The age incidence of pulmonary tuberculosis generally has shifted from young individuals to males in the older age group (11). A few cases are reported for the first time only when the patient is dying and many others are far advanced when first discovered. The high

mortality rate in the colored shows that this race, once the disease is acquired is more susceptible to the end results of the disease (12). Stronger efforts must be made for early diagnosis and effective treatment.

Up to the present, any efforts to immunize against this disease have been mostly experimental or limited to very small groups. There has been no definite program of immunization established by the County Health Department at the present time. This must await more conclusive evidence.

The ultimate objective of the control program in tuberculosis is eventual eradication of the disease. The Baltimore County Health Department looks hopefully toward that day. With our present methods this can be accomplished only by a strong and persistent program of case finding and, once that case is found, to prevent any further spread of disease from that source. Some real evidence of the results of the vigorous anti-tuberculosis campaign in Baltimore County is the tremendous decline in the tuberculosis death rate from 1940 to 1953.

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PREVENTIVE DENTAL HEALTH IN BALTIMORE COUNTY

NORVAL H. McDONALD, D.D.S.*

If dental caries were a communicable disease a great many people would want to know why something was not being done about it. The records show that dental caries is our most prevalent disease. It is astounding, but true, that about 95 per cent of all the people over three years of age are affected. In spite of the prevalence of dental caries it has been demonstrated that only about 25 per cent of the people affected receive routine dental care. The really pathetic fact about this situation is that the group which is most in need of dental care, the elementary school age child is the most neglected (1).

The dental profession has been trying for many years to develop educational programs which would appeal to the public and at the same time awaken the people to the great need for dental care. The profession has also sponsored much research on dental caries in the hope of finding the cause or causes. If the cause could be found, it might be possible to reduce the incidence of the disease. Research has led to the discovery that dental caries was consistently lower in communities where the public water supply contained variable amounts of fluoride salts and as a result of further research many communities are adding a fluoride to their public water supplies. Where this has been done over a period of several years there has been a marked

reduction in the prevalence of dental caries, especially in children. A fluoride is being added to the public water supply in Baltimore city, but since all the people of Baltimore County are not supplied with water from Baltimore city, it will be difficult to evaluate the results as far as the County is concerned.

The Baltimore County Health Department and the Board of Education of Baltimore County have long been aware of the need for dental care and they jointly sponsor the dental health program. The original program resulted from a proposal made by the Maryland State Dental Association a number of years ago that a dentist be appointed to the State Board of Health and that the State Department of Health be required to employ a dentist to administer a dental program on a State-wide level. For several years, however, the clinical service for pupils in the first three grades and a survey or inspection service for pupils in the upper elementary grades were all that could be planned to further dental education in the schools of Baltimore County. Two factors limited the scope of the program: (1) in the past the part time Health Department dental supervisor could devote only so much time to administering the program; and (2) there were insufficient dentists to conduct clinics in every elementary school where dental clinics were desired. The first limiting factor was corrected, at least in part, in 1952 when the writer was ap-

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pointed as the first full time Director of the Division of Dental Health of the Baltimore County Health Department through the joint efforts of Dr. William H. F. Warthen, Health Officer of Baltimore County, and Dr. Richard C. Leonard, Chief of the Division of Dental Health of the Maryland State Department of Health. The other limiting factor is a difficult one to overcome, since it is a personal problem concerning each individual dentist. The recently organized Baltimore County Dental Association may be able to assist in the procurement of more part time clinicians and it is hoped that the individual members will help in the development of educational projects in the schools by serving as dental consultants.

THE CLINICAL SERVICE

The clinical program as it now exists is a co-operative program wherein the clinics are sponsored by the Parent-Teacher Association of the school where a clinic can be conducted, with additional funds provided by the Baltimore County Health Department and the State Department of Health. This makes it possible for parents to have their children's dental needs provided at a nominal cost. It is not a free service, although sometimes a Parent-Teacher Association arranges to take care of children whose parents are unable to do so. It is not intended to make a profit from any clinic and this seldom occurs, since the prevailing fees are kept as low as possible in relation to what is paid to the clinician. Since there has never been a sufficient number of clinicians to operate a clinic in every elementary school, or to extend the service to children in the upper grades, even though they might need dental care as much as the lower grade group, only a relatively small number of children in proportion to the number who need such care have received it.

The records show that during the past school year of 1953-1954 there were 8,263 pupils examined in the 22 elementary schools where dental clinics were conducted. Of this number a total

of 5,937 or 71.9 per cent had dental defects. Complete dental care was given to 1,894 pupils, or 31.9 per cent of those children found to have dental defects. Only 92 pupils of the remaining 4,043 with defects returned certificates stating that they have received all necessary dental care from family dentists.

THE SURVEY SERVICE

The dental survey service had been used previously for pupils in the upper grades in those elementary schools where a dental clinic was conducted or for pupils in all elementary grades in schools where a dentist was not available to conduct a clinic. This form of dental service is not approved by many public health dentists since the school dentist does not actually examine the teeth; he simply classifies each child as having satisfactory or unsatisfactory teeth. For this reason its use in Baltimore County during the 1953-1954 school year was minimized and the advisory services (see below) received greater emphasis. In the five schools using the service a total of 1,616 pupils was surveyed or classified and a total of 991 or 61.3 per cent was found to be unsatisfactory. Only 54 of the 991 or 5.5 per cent returned certificates stating that they had received all necessary dental care from a family dentist.

THE ADVISORY SERVICES

Prior to 1953 no effort was made to promote dental health education in the non-clinic schools except where a classroom teacher or a public health nurse instituted a dental health project in connection with the regular teaching program. In order to reach the parents of pupils in all the elementary schools two recent dental advisory services have been inaugurated in Baltimore County: (1) a preschool service; and (2) an elementary school service.

Preschool Advisory Service. The preschool dental advisory service was introduced in the spring of 1953 at the preschool roundups with better results than were anticipated. Parents

who registered children at a preschool roundup received a letter which stressed the importance of child dental care and advised that the children be taken to a private dentist for a dental examination and dental care if needed. A great many of the parents followed the advice with the result that for the 59 elementary schools which used the service and from which completed reports were received, a total of 37 per cent of the children entered school in the fall of 1953 with acceptable "OK" or satisfactory teeth, according to the certificates received from practicing dentists.

Elementary School Advisory Service. The other advisory service, for use in elementary schools, was made available when schools opened in the fall of 1953. As in the preschool advisory service, the letter to the parents stressed the importance of dental care and encouraged the parents to take their children to a private dentist for a dental examination and care if needed, and return a certificate, prepared by the Health Department, properly checked and signed by a dentist. This service was used in twelve of the clinic schools for one or more upper grades and in seventeen non-clinic schools with variable results, as had been anticipated.

For the twenty-nine schools where the service was used throughout or in part, the reports received showed that a total of 14,236 letters was distributed, and a total of 2,143 pupils had acceptable "OK" or satisfactory teeth according to the certificates signed by dentists. The percentages ranged from 1.5 to 49.9 with an average of 15.1 per cent for the 29 schools. Most of the schools at the top of the list are located in the

more metropolitan areas where there are more practicing dentists. The schools located in the more rural areas where there are only a few, if any, practicing dentists made a poorer showing. The result, however, was as good or better than was anticipated. However, these figures show that there is still a great deal to do in the way of dental health education.

SUMMARY

The dental health program in Baltimore County as presently organized must be considered as a long range program. It is well planned and sufficiently diversified to reach every elementary school in the County. The weak links must be strengthened, if possible, by: (1) encouraging teachers to integrate dental health with daily classroom teaching; (2) encouraging school principals to develop school-wide projects on dental health; and (3) developing better contacts with Mothers' Clubs and Parent-Teacher Associations to awaken parents to the great need for dental care and for the need of cooperating with the existing program. The clinic program should be improved so that more rural school children may receive dental care. It is hoped that the recently organized Baltimore County Dental Association will cooperate with the Baltimore County Health Department in trying to procure the services of more dentists.

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Scientific Papers

DERMATOLOGIC EXPERIENCES AT A HOSPITAL FOR THE MENTALLY RETARDED*

ISRAEL ZELIGMAN, M.D., MED. SC.D. AND SAMUEL P. SCALIA, M.D.

During November 1951, a dermatology clinic was set up at the Rosewood State Training School, a hospital for the mentally retarded. This clinic has met usually every two weeks for an entire afternoon. There, patients have been examined, subjected to laboratory procedures when indicated, and treatment outlined or directly administered. Because of the mental status of most of the patients, it has been impossible to obtain an adequate history from most of the patients. All patients, except when special studies or epidemics have been pursued, have been referred to the dermatology clinic by the resident physicians or by other specialty consultants.

This study refers to those patients examined and treated from November 1951 through April 1954. During this interim, the census of the institution has varied between 1274 and 1553. The oldest patient was 76 years old and the youngest 2 months. The sex ratio has averaged males/females = 1.3; all inmates were white. The average number of admissions each year has varied from 106 to 298. Discharges from the institution have varied from 50 to 103 each year and deaths from 9 to 47. This report, it must be emphasized, is not a statistical survey of the entire institution at any one time; it merely concerns those patients referred to the dermatology clinic and to other cases particularly pursued because of special interest.

Of those patients seen in the clinic there were 134 females and 111 males. Many of those with chronic dermatoses were seen repeatedly and

some patients of course had more than one dermatosis. A special study of the dermatologic manifestations of mongolism (1), not included in this report, has previously been published.

BACTERIAL DISEASES (Table I)

Many pyoderma both primary and secondary, were seen. As noted, there were 16 cases of pyoderma involving combinations of impetigo and ecthyma. There were 14 cases of impetigo contagiosa per se and 4 of ecthyma alone. Other dermatoses which were secondarily infected accounted for 8 cases. There were 5 cases of infectious eczematoid dermatitis mostly from foci of otitis externa or media. There were scattered cases of folliculitis, furuncles and cellulitis.

TABLE I
Bacterial Diseases

Pyoderma.....	16
Impetigo Contagiosa.....	14
Impetiginized Dermatitis.....	8
Infectious Eczematoid Dermatitis.....	5
Ecthyma.....	4
Folliculitis.....	2
Furuncle.....	2
Cellulitis.....	1

In general, most cases with local involvement were treated with chlortetracycline ointment. Those of a more generalized distribution or of less superficial manifestation received systemic chlortetracycline, erythromycin or penicillin. When indicated, patients were transferred from their cottages to the hospital for better observation and more careful and definitive nursing care. Results of therapy were very satisfactory.

* From the Rosewood State Training School, Owings Mills, Md.

TABLE II
Viral Diseases

Verruca Vulgaris.....	10
Molluscum Contagiosum.....	4
Verruca Plantaris.....	2
Herpes Simplex.....	1
Rubella.....	1

VIRAL DISEASES (Table II)

Some dermatoses of viral etiology were seen in the dermatology clinic. There were 10 patients with verruca vulgaris, some with multiple lesions, and all of whom were successfully treated with electrodesiccation and curettage. In a few instances, bismuth therapy was attempted but these were uniformly unsuccessful. Two patients with plantar warts received topical therapy since neither had discomfort severe enough to warrant radiation or surgical treatment.

Four patients with multiple lesions of molluscum contagiosum were treated with curettement. Individual cases of herpes simplex and of rubella were also encountered.

PARASITIC DISEASES

Only 3 patients with scabies were actually seen in the clinic. When these were recognized however, a follow-up visit was paid to the two cottages housing a total of 200 inmates virtually all of whom had scabies. Considerable difficulty was encountered when sulfur ointment 10% was used because of the messiness of application to these difficult-to-handle patients. When Eurax cream was applied daily for two days to these inmates, a dramatic result ensued, putting a quick cessation to the epidemic.

TABLE III
Fungous Diseases

Tinea Capitis.....	5
Tinea Corporis.....	4
Tinea Versicolor.....	4
Paronychia.....	2
Perleche.....	1
Tinea Manis.....	1
Tinea Pedis.....	1
Onychomycosis.....	1

FUNGOUS DISEASES (Table III)

Over the 30 months of study, 5 patients with tinea capitis were seen. They were all found to be caused by Microsporon Audouini. Because of the difficulties involved in patient cooperation, x-ray epilation was not attempted. Only topical therapy was used and at present writing (July 1954) 3 patients continue to harbor the infection. One of these has to our knowledge shown no improvement for over 2 years.

Four patients with tinea corporis were successfully treated with ammoniated mercury ointment 10%. Four patients were seen with tinea versicolor, 2 with monilial paronychia, and one each with perleche, tinea manis, tinea pedis and onychomycosis. It is obvious that there are probably several hundred inmates with tinea pedis at the institution, but only one was referred because of it.

ALLERGIC DISEASES (Table IV)

Some 15 cases of contact dermatitis were seen. Some were of allergic causation such as due to plant oleoresins, medications, etc., while most were due to primary irritation reaction caused by soaps and detergents. Many patients are given part-time occupations and some of those who were engaged in dishwashing and in clothes washing developed primary irritation contact dermatitis of the hands. The relatively small number of cases of contact dermatitis was a great surprise when one considers that this entity is the leading diagnosis in the private practice of one of us. (I.Z.)

There were 7 cases of atopic dermatitis of quite typical variety and there were 2 cases of lichen chronicus simplex which entity is classi-

TABLE IV
Allergic Diseases

Contact Dermatitis.....	15
Atopic Dermatitis.....	7
Lichen Chronicus Simplex.....	2
Erythema Nodosum.....	2
Absorption Dermatitis.....	1
Dermatitis Medicamentosa.....	1

TABLE V
Endocrinological Disorders

Acne Vulgaris.....	48
Seborrheic Dermatitis.....	27
Rosacea.....	3
Generalized Myxedema.....	2

fied here but could easily be placed in other disease groups. There were also 2 cases of erythema nodosum, 1 of absorption dermatitis and 1 of dermatitis medicamentosa.

ENDOCRINOLOGICAL DISORDERS (Table V)

The greatest number of cases seen in any one category was of acne vulgaris. This was undoubtedly due to the large number of inmates in their teens and twenties. Many of these patients were quite concerned with their appearance and the acne lesions represented an important defect. Others were of such low mental calibre that they were referred only because the resident physicians were desirous of dermatologic help for them. Therapy was limited to topical medications only except for one patient who improved considerably with radiation therapy.

Another large category was seborrheic dermatitis with 27 cases. The exact reason for this relative high incidence (27 compared with 15 cases of contact dermatitis) was not determined but might have been due to the difficulties encountered in the performance of an adequate number of shampoos on the patients. The therapeutic response to more frequent shampoos and to topical therapy with sulfur-salicylic acid-tar preparations was gratifying.

Three cases of rosacea were seen. Topical therapy alone was used and the results were indifferent.

Two cases of generalized myxedema were so uncooperative that basal metabolic rates could not be adequately performed. The dermatology clinic was called upon for aid and histologic study of the skin confirmed the clinical and other laboratory evidence of myxedema.

TABLE VI
Psychodermatoses

Localized Hypertrichosis.....	16
Neurotic Excoriations.....	8
Alopecia Areata.....	3
Trichokryptomania.....	1

PSYCHODERMATOSES (Table VI)

There were 16 patients, all idiots, with localized acquired hypertrichosis and callous formation. Similar to the patients reported by Reissman and Butterworth (2), the lesions resulting from chronic repeated trauma, were all on the dorsa of hands, the wrists and the forearms. All except one occurred in those who were self-biters, while one with marked linear lesions of hypertrichosis on the forearms was a self-scratcher (Fig. 1).

Though only 8 cases of neurotic excoriations are recorded, there were more but some are included among the pyodermas since the bacterial infection was the foremost problem when seen in the clinic. There were in addition 3 patients with alopecia areata and one with trichokryptomania.



FIG. 1. Localized acquired hypertrichosis

TABLE VII
Other Inflammatory Dermatoses

Psoriasis.....	12
Dermatitis Hiemalis.....	4
Pityriasis Rosea.....	2
Lichen Planus.....	1
Intertrigo.....	1
Thermal Burn.....	1
Nummular Eczema.....	1

INFLAMMATORY DISEASES OF UNKNOWN
OR OTHER ETIOLOGY (Table VII)

Twelve cases of psoriasis were seen. Some responded well to topical and ultra-violet therapy while others were recalcitrant to many different therapeutic approaches. There were 4 cases of dermatitis hiemalis, 2 of pityriasis rosea, and individual cases of lichen planus, intertrigo, nummular eczema and of thermal burn.

TUMORS (Table VIII)

Many skin tumors were encountered. Seven patients were referred to the skin clinic because of benign pigmented nevi. Most of these were excised and were subjected to histologic investigation in order to rule out malignancy.

Six patients with adenoma sebaceum were seen. All had evidence of tuberous sclerosis and epiloia. Biopsies were taken of the facial papu-

TABLE VIII
Tumors

Benign Pigmented Nevus.....	7
Adenoma Sebaceum.....	6
Sebaceous Cyst.....	5
Nevus Flammeus.....	3
Sturge-Weber Syndrome.....	3
Angioma.....	3
Seborrheic Keratosis.....	3
Callositas.....	2
Keloid.....	1
Neurofibromatosis.....	1
Epidermic Nevus.....	1
Subepidermic Nodular Fibrosis.....	1
Angioneuroma.....	1
Granuloma Pyogenicum.....	1
Basal Cell Carcinoma.....	1

lar lesions and also of the nodular pigskin-like lesions. The histologic studies confirmed the findings of Weidman in the classic article of Butterworth and Wilson (3) that the term "adenoma sebaceum" is a misnomer since there was no evidence of sebaceous gland hyperplasia. On the other hand there was evidence only of fibrous hyperplasia.

Three patients with simple nevus flammeus were seen and in addition there were 3 others with involvement of the face associated with the Sturge-Weber syndrome. These revealed not only clinical manifestations but also roentgenologic confirmation of this abnormality.

Other benign and premalignant tumors were seen and in addition there was one case of basal cell carcinoma.

MISCELLANEOUS DERMATOSES (Table IX)

Of the miscellaneous group of dermatoses, several were of particular interest. Two patients with decubitus ulcers of the scalp were seen in the clinic but a number of others were found in the nursery where the management of decubitus ulcers of the scalp of hydrocephalics represents a difficult problem.

Cutis verticis gyrata was seen in one patient. The association of this rather rare abnormality with mental retardation has recently been attested by Polan and Butterworth (4) who in a review of the literature found that 28% of cases of cutis verticis gyrata occurred in persons with neuropathic traits; they personally noted 6 cases in mentally retarded persons.

TABLE IX
Miscellaneous Dermatoses

Alopecia Prematura.....	4
Ichthyosis.....	3
Localized Scleroderma.....	2
Decubitus Ulcers of Scalp.....	2
Miliaria Rubra.....	1
Vitiligo.....	1
Anonychia.....	1
Secondary Macular Atrophy.....	1
Cutis Verticis Gyrata.....	1

COMMENT

Not only has the skin clinic performed a diagnostic and therapeutic service at the Rosewood State Training School, but it has served as an excellent means of investigation of the various dermatoses seen at a hospital for the mentally retarded. It has afforded an opportunity to compare cases seen at such an institution with those seen in private practice and in dermatology clinics in general hospitals.

The great number of pyodermas, acne vulgaris and seborrheic dermatitis has been noted as well as the relative paucity of contact dermatitis. In addition, localized acquired hypertrichosis, adenoma sebaceum, and Sturge-Weber syndrome, seen uncommonly in ordinary practice, were studied and observed. As previously noted, the dermatologic manifestations of mongolism have been reported in a previous com-

munication. All in all, the institution and management of the skin clinic have been interesting, educational and well worthwhile.

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PSYCHIATRIC RESEARCH IN A STATE PSYCHIATRIC HOSPITAL¹

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The State of Maryland has over 10,000 beds in its state psychiatric hospital system. More beds continue to be needed as the patient population increases in spite of the application of all the recognized treatment procedures. The cost of the care and treatment of this staggering burden of illness runs into the millions. What it costs in terms of the suffering of the patient and his close ones is incalculable. A problem of

this magnitude presents unceasing and ever-increasing demands for solution or a defensive pattern of apathy, indifference and inertia results. In the past as we know only too well, the state psychiatric hospital became the custodial center to store those human beings for whom medical science had little to offer. In the more recent decades with the discoveries of Freud and his co-workers and their application to the treatment of the mentally ill plus the introduction of the shock therapies, there has been brought about a changing role in the state psychiatric hospital and its emergence as an active treatment center. This is indicated by an admission rate which exceeded 1200 admissions for the past year.

One of the results of this movement has been

¹ It is with a great deal of pleasure that the author acknowledges the help and support of Dr. Isadore Tuerk, Superintendent of the Spring Grove State Hospital; Dr. George Sutherland, Director of Psychiatric Education and Research of the Department of Mental Hygiene; and Dr. Clifton Perkins, Commissioner of Mental Hygiene. Without their help and support and constant encouragement, this program would not have been possible.

² Director of Medical Research, Spring Grove State Hospital, Catonsville, Maryland.



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an increasing challenge for more effective treatment procedures. The question is asked with increasing frequency, "What can psychiatric research contribute?" When we attempt to answer this challenge, we have been confronted with a paradoxical state of affairs. Where there are the most psychiatric patients, there has been the least psychiatric research. Recently this phenomena has begun to engage the serious consideration of such leaders in psychiatric research as Kubie (1) and Gottlieb (2). What is there about psychiatric research, especially on the state psychiatric hospital level, which has kept it in such an inactive state?

An approach to this problem was made from two directions, using the Spring Grove State Hospital as the object of study. One was to prepare a roster of the physicians who had been at this hospital since its founding over 155 years ago. Through the assistance of the librarians of the Medical and Chirurgical Faculty Library, the titles of any publications written by physicians while on the Staff of the Spring Grove State Hospital were sought. The sum total was that there was little handed on to posterity except for the sporadic efforts of some very energetic physicians. In fact in a bulletin (3) commemorating the 150th anniversary celebration of the founding of the hospital, there is only a paragraph detailing the research efforts at this hospital which has pioneered in such things as the introduction of the shock therapies and volunteer services into the state hospital.

The second phase of this investigation, namely, the nature and evaluation of the problem encountered in the development of an active research program in a state psychiatric hospital, was formulated in a paper published in the Bulletin of the School of Medicine of the University of Maryland (4). One of the most important factors which came out of that study was the need for a supporting structure to carry on an organized research program in a

hospital crowded with patients and overburdened personnel.

As a result of this recognition and the developing awareness of the potentialities of the state psychiatric hospital for both basic and applied research, the administration of the Spring Grove State Hospital, through the Department of Mental Hygiene of the State of Maryland, organized a research department, and in July, 1954, it completed its first year of service.

The nature of the operations which have developed in the past year as this research unit began to become integrated into the operating routines of the hospital fell into two main categories. One was the research projects which originated to meet problems in a hospital setting and which could be approached for investigation with the means available and, secondly, assistance which could be rendered to other institutions and their investigators in providing the means to carry out special studies.

In the first category there were several projects. An investigation was begun to study all patients who had been committed to the hospital in the past 25 years who had acted out a homicidal impulse. On the basis of a classification of the victims in relationship to their assailants, it was found that the largest group of assailants were those that murdered their wives. This then became an object for special study and resulted in a paper entitled, "A Comparative Study of Wife Murderers" (5). From this investigation of this group of patients and a comparative study of a group of patients and their wives who had survived a homicidal assault, a group of factors in evaluating the homicidal potential of the marital setting were formulated. These were: (1) An increasing degree of the acting out of hostile impulses by verbal threats, threatening use of weapons or physical assaults; (2) a history of increasing alcoholism; (3) increasing emotional clashes as the results of expressions of pathological jealousy, ideas of infidelity and persecution; (4) an increasing limitation

and dissatisfaction with sexual expression in the marriage, and (5) an increasing inability to discuss their emotional conflicts with each other. There was emphasized the need to learn the relationship of the wife to the husband in terms of her attempts to control his behavior. Is she resorting to the increasing use of guilt while she attempts to hold herself to be blameless? Does she increasingly threaten her spouse with uncertainty about the maintenance of their marriage and at the same time denying his dependent needs? Where an attack has been made and the victim has survived, the problem that the psychiatrist faces in dealing with the manifestations of such sadomasochistic relationships is an area in which continuing investigation is going on to determine the best therapeutic means of dealing with such a potentially laden setting for tragedy.

An outgrowth of the original project is being carried on at the present time, namely, an investigation into the factors which led to the second largest group of victims, children. It has been found here that it is the mother who kills in the great majority of the cases. What can be done from an understanding of the psychodynamics to help prevent such catastrophes from occurring is under investigation.

One of the areas in which the hospital administration has concentrated a great deal of study has been that of the care and management of the criminally insane. This has led to an investigation of the attendants and the care of the criminally insane (6). This project was designed to study the factors which might help to bring about a more effective therapeutic milieu in this division of the hospital. It also introduced the electronic recording of attendants' reports which gave a one-step communication between doctor and attendant instead of the usual transmission of information from attendant to charge attendant to supervisor and then physician, with a marked increase in patient care.

An attempt was made to evolve a method of evaluating quantitatively the effectiveness of

a music therapy program, using a group of chronic, regressed, schizophrenic patients, but no clear-cut formulations could be reached because of the difficulties in designing adequate controls.

The second category of service in which the research department was able to be of assistance was in the aiding of other institutions and their investigators in carrying out special studies such as (1) quantitative studies of the phenolic amines in the cerebrospinal fluid of certain types of patients; (2) the effect of lysergic acid and mescaline in changing the mental status of chronic, regressed, schizophrenic patients; (3) the effects of anxiety induced by experimental stress on the performance of the damaged brain; (4) the relationship between color choice and affective state in a group of male paranoid patients, and (5) brain tumors and their resulting psychological disorders.

In the year ahead, it is expected that the following projects which are under investigation will have reached a point where sufficient data will have been obtained to lead to formal presentations: (1) A comparative study of the accident rate of the Spring Grove State Hospital. An analysis is being made of the number of accidents occurring in the various divisions of the patient population of the Spring Grove State Hospital over a one year period and the factors influencing the accident incidence. (2) A systematic study is being made to develop standards of comparison of the rate of recovery of memory function in patients receiving electric shock. (3) Studies are being carried out on the use of Thorazine (Chlorpromazine) in the management of acutely disturbed patients in which a series of about 50 patients will be evaluated. (4) A study is being carried out to evaluate the effect of the alkaloids of *Rauwolfia Serpentina* in the management of tension states. (5) The status of the Funkenstein Test is being reviewed due to the conflicting reports as to the value of this procedure as a prognostic indicator in various treatment procedures. (6) An evaluation of Hyaluranidose in insulin

coma therapy is being conducted. The introduction of this agent as a means of bringing about an acceleration of insulin coma and a decrease in post-coma reactions appears to be controversial. It is hoped through our series of cases to shed further light on this matter.

While the research program of the Spring Grove State Hospital has been outlined, it is not meant to be presented as a rigid one. Day to day problems and the evolution of any data and information which might lead to more significant contributions would take priority in the planning and constant designing of experimental procedures which can be fitted into the daily operating routines to yield the clinical information available in a hospital of almost 3,000 beds. A goal which the research service is striving for is an expansion of the budget to the point where it will be possible to have the necessary personnel to carry on the multidisciplinary approach so necessary to modern dynamic psychiatric research. It is also hoped that funds may be secured to provide compensation for members of the Staff who may wish to carry out investigations as an extra curricular activity in

the free time available to them. It is also hoped that a state of affairs can be reached whereby the practicing psychiatrist in the community will be able to avail himself of the facilities for doing research to complement the assets of his years of clinical experience.

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PROPER PLACEMENT OF INDIVIDUALS WITH CORONARY ARTERY DISEASE*

DONALD J. ROOP, M.D., M.P.H. AND RICHARD H. SIEDENBURG, M.D.

There are many reports concerning the work potential of cardiacs and it is generally agreed that the majority of cardiacs can be gainfully employed (1, 2, 3, 4). Coronary artery disease accounts for the largest group of these partially disabled employees and as a rule pain is their chief limiting symptom. However, little has been written about placement of cardiacs in specific type jobs and their ability and performance in such jobs. It is the purpose of this

paper to present a small series of employees of the Delaware-Maryland-District of Columbia Sales Division and of the Baltimore Refinery of the Esso Standard Oil Company. These employees have coronary artery disease and a summary of their job experience in a particular type of job placement will be made. Proper placement of employees with coronary artery disease depends on a number of factors such as the extent of disease, presence of myocardial infarction, age, extent of symptoms and probably most important on cardiac reserve. Other

* Presented at the annual meeting of the Esso Standard Oil Medical Department, Baton Rouge, La., March 24, 1954.

factors to be considered are proper diagnosis, type of treatment, and attitude of the employee toward his disease and degree of cooperation.

First, the diagnosis must be verified before an employee is placed in the classification of having coronary artery disease. Recently Goldwater, Bronstein and Kresky reported 175 persons treated as cardiacs and who were severely restricted as to activity when no cardiac disease was present (5). This is a common occurrence in which a great disservice is done to the individual and to his family.

As progress is made in better understanding of the pathogenesis, treatment and prevention of coronary artery disease, it is apparent that occupational opportunities for these individuals should increase.

In the last several years there has been controversy over the role of cholesterol and fat in the diet on the progress of atherosclerosis and the beneficial effects of limitation of these substances in the diet both in prevention and treatment of coronary atherosclerosis. Another controversial issue is the use of anticoagulants particularly for the treatment of myocardial infarction, but also for the prevention of impending myocardial infarction. Morrison (6) concludes that a low fat-cholesterol diet gives a better survival rate after myocardial infarction and also found that those patients on a low fat cholesterol diet had significant lowering of total serum lipids and serum cholesterol. Other investigators (7, 8, 9) have found that in normal subjects serum cholesterol is highest in the endomorphic body type, next highest in the mesomorphic type and lowest in the ectomorphic type, with, of course, most coronary artery disease occurring in the mesomorphic body type. Also serum cholesterol normally rises from the 3rd to the 6th decade. It was further found that serum cholesterol is independent of cholesterol intake in normal individuals. Such findings might indicate that increased serum cholesterol occurs coincidentally with coronary artery disease. It is probable that there is a disturbed

cholesterol metabolism in coronary artery disease rather than an increased cholesterol intake and that only individuals with such a disturbed metabolism need restrict their cholesterol intake. The current recommendation (10) is a low fat and low cholesterol diet in coronary artery disease. Also anticoagulants are generally recommended if not specifically contraindicated by poor nutrition, deficient vitamin K and hypoprothrombinemia due to liver disease, old age or vitamin C deficiency. These factors are of importance as they may affect the prognosis and the functional capacity of the individual.

Another pertinent clinical consideration is the type of activity which precedes angina and myocardial infarction. According to Schaaf, effort or emotion precedes every attack of angina while effort or emotion precedes only 1.9% of myocardial infarctions (11). Although this isn't universally accepted (12) it is well known that effort does not usually precipitate myocardial infarction. Along the same lines as this observation, epidemiological studies have been made in England (13) on coronary artery disease. In transit workers, the drivers have a higher incidence of coronary artery disease than do the conductors who have a more active job. Also postal clerks have a higher incidence of coronary artery disease than do letter carriers. Several million (14) industrial workers were studied as to relation of job to death from myocardial infarction. Those classified as light or sedentary workers had the highest death rate from myocardial infarction, those with intermediate jobs a lower rate and those with heavy labor had the lowest rate. This high rate in sedentary workers can not be attributed to increased responsibility because it was found that the rate was approximately the same for clerical workers as it was for executives.

It has been stated that 50% of men over 45 years of age have some degree of coronary degeneration (10), so it may be well to review some of the clinical evidence of myocardial ischemia.

Angina Pectoris
Myocardial infarction
Congestive heart failure
Atrioventricular block
Intraventricular block
Inversion of T Waves
Arrhythmias—auricular flutter and auricular fibrillation

This list of symptoms and findings as outlined by Sprague (10) makes it logical to classify persons with coronary artery disease into the following three categories:

- I. Coronary artery disease with angina pectoris or other symptoms
- II. Coronary artery disease with myocardial infarction
- III. Coronary artery disease manifested only by EKG evidence and without symptoms

The extent of symptoms and the resultant classification determines the placement of the individual.

A study has been made of 24 employees who have coronary artery disease in the Delaware-Maryland-District of Columbia Sales Division and the Baltimore Refinery. Of this group 13, or 54%, have had proven myocardial infarctions; 4, or 16%, have had suspected infarctions and the remaining 7, or 30%, have coronary artery disease with symptoms. Before further comment is made on this group of employees it should be explained that this group comprises only employees in Class I or Class II, that is, they either have symptoms or have had myocardial infarctions and present a placement problem. Those individuals in Class III, or who have only EKG evidence of disease, are not included in this series as they present no unusual placement problems.

Table I shows the diagnosis by age group of employees with coronary artery disease who are currently working. Table II shows the type of work these individuals are engaged in. The work has been classified as light or sedentary, as intermediate, which includes some walking, climbing or driving, and as heavy, which is labor

TABLE I
Age and Diagnosis of Employees with Coronary Artery Disease

Age	Number	Diagnosis		
		Myocardial infarction	Suspected myocardial infarction	Coronary insufficiency
Under 35	1	—	1	—
35-50	9	6	1	2
51-60	12	7	1	4
Over 60	2	—	1	1

TABLE II
Type of Work Employees with Coronary Artery Disease Are at Present Engaged in

Type of Work	Number of Employees
Light or sedentary.....	17
Intermediate.....	7
Heavy.....	—

TABLE III
Employees in Whom the Occurrence of Coronary Artery Disease Necessitated a Change of Assignment

Change in Assignment	Number of Employees
Heavy to light.....	1
Intermediate to light.....	3
Heavy to intermediate.....	1
Light to limited light.....	2
Total.....	7 or 29% of entire group

and certain trades work. No employee in this series is assigned to heavy work. Table III indicates that less than one-third of these employees have needed a change of job assignment. This also shows that only one individual in this group was ever classified as doing heavy work. Otherwise, it is very likely that some of these people could have continued at heavy work. A few employees have not had a change in assignment but have been restricted to avoid overtime, shift work and restricted to ground level jobs.

This group of employees who are working productively at present have an average duration of their disease of 5.4 years which, of course,

TABLE IV
Duration of Coronary Artery Disease in This Group of Employees

Age	Average Years Duration
Under 35	2
35-50	4.5
51-60	6
Over 60	9.5

Entire group has average duration of 5.4 years.

TABLE V
Occurrence of Symptoms in Group with Coronary Artery Disease

Occurrence of Symptoms	Number
Symptoms absent.....	6
Symptoms occur, but not disabling.....	15
Symptoms occur and are partially disabling....	4

increases with their present age. From this it appears that the prognosis is favorable. Symptoms occur in 19 of these employees but are only partially disabling in 4. These symptoms are usually transient anginal pain, dyspnea on effort, or recurrent arrhythmias. Five of the six individuals without symptoms have had myocardial infarctions.

COMMENTS

No attempt is made to draw statistical conclusions from this limited series of cases, but it would appear that employees who develop coronary artery disease can continue working and in most instances continue at their regular assignment. A significant number of persons with coronary occlusion have been reported to have made full functional recoveries and an even greater proportion of individuals with acute coronary insufficiency made complete functional recovery (15). This limited experience correlates closely with that of Morris and Heady (13) who found that coronary artery disease occurs in employees doing light or intermediate type work, rather than heavy work. Such a group of employees should be kept under close medical supervision and their capacity to continue their regular work carefully evaluated.

If a person can continue at a job he has been trained for, he may expend less effort than being given a lighter but strange type of job. It is also psychologically beneficial if an individual does not have to be restricted or changed to another job.

Proper placement of individuals with coronary artery disease must be based on all available knowledge including clinical observation, electrocardiographic and other laboratory data as well as an evaluation of functional capacity. It should be remembered that activity is beneficial. As more progress is made in the understanding of the pathogenesis and as adequate treatment, which may well include surgical means of increasing coronary blood supply (16), is available recommendations as to proper placement will of necessity change from time to time.

The question is often raised as to when an individual can return to work after a myocardial infarction. The present tendency is toward earlier ambulation and earlier return to activity. In the usual patient, depending on age and general condition, one month in bed or in bed and a chair, one month of increasing activity, and one month of part time work is a recommended schedule. This may seem rather fast, but probably effective collateral circulation is completed after the first few weeks. One is also influenced by the EKG becoming stabilized and the sedimentation rate returning to normal.

With the emphasis of industrial medical programs being preventive in nature, it is well to apply present knowledge where practical to forestall coronary artery disease. Certainly efforts should be made to maintain normal weight and the desirability of limiting fat and cholesterol should be considered, particularly in those cases in which it might be suspected that there is a disturbed cholesterol metabolism. Early recognition and careful evaluation before cases become placement problems are helpful. Continuing epidemiological and clinical studies as well as laboratory studies are indicated.

SUMMARY

1. The work experience of a small group of oil industry workers with coronary artery disease has been presented.

2. Seventy percent of these workers have been able to continue in their regular job.

3. Only one employee was engaged in heavy work at the onset of his disease.

4. A brief review of more recent work on coronary artery disease which might affect proper placement has also been presented.

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THE ROLE OF TRACHEOTOMY AND BRONCHOSCOPY IN BULBOSPINAL POLIOMYELITIS

JOHN MARTIN REHBERGER, M.D.*

Tracheotomy and bronchoscopy may be the deciding factor in the survival of a patient with bulbospinal poliomyelitis. With depression of the respiratory centers, constant vigilance must be maintained to combat anoxia. The anoxia initiated by this depression is aggravated by the

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accumulation of secretions in the tracheobronchial tree and alveoli, due to the depression or loss of the cough reflex, inability to swallow, and loss of the tussive action of the trachea and bronchi. As a result of this tracheobronchial stasis, the patient may develop a "drowned lung." The bronchi and bronchioles become obstructed with resultant atelectasis and infection.

Too frequently one procrastinates before tracheotomy is finally done. In the meantime, anoxia increases, and the patient becomes more fatigued. A tracheotomy is a benign procedure, and may be done at the bedside. It is much more tiring to the patient to attempt aspiration of the trachea and bronchi through the nose and mouth than to aspirate through the tracheotomy. With the former, it may be a hit or miss procedure, with only occasional entrance into the trachea, while the lung fills up with secretions inadequately aspirated. After tracheotomy one is sure to enter the lung and is better able to maintain a dry tree.

Suction via the tracheostomy may be inadequate either through failure to have a proper catheter, failure to introduce it as far as possible in the bronchus, or failure to gently manipulate it up and down, both main stem bronchi. The catheter should be firm, not soft, and should be trimmed so that the suction end is beveled, with only one fenestrum just above the tip. Suction is much better with this type of catheter. The catheter should be cleared at intervals, in saline, to free mucous plugs that may block the lumen. Between aspirations, the catheter should be kept in a solution, such as hydrogen peroxide. Tracheobronchial lavage with a small quantity of normal saline between aspirations helps to loosen mucous plugs and flush the bronchi.

Tracheostomy with suction is not always satisfactory and has to be supplemented by bronchoscopy via the tracheostomy. Since the catheter can only keep the main stem bronchi clear and produce a small amount of negative pressure at the ostia of the smaller bronchi, one may have to use a flexible curved tip metal aspirator. Where there is atelectasis, as in an upper lobe, a small bronchoscope may be introduced through the 'ostomy and the mucous plug may be removed with the flexible curved tip metal aspirator.

The following case presentation points out the value of supplementary bronchoscopy to tracheostomy and suction. With this technique

atelectatic upper lobes may be cleared and aerated and the lungs maintained in a healthy state.

CASE PRESENTATION

A 23 year old male was admitted on August 15, 1953 to a US Army Hospital in Germany with fever, headache and nuchal rigidity. He had been in good health until 6 days prior to admission, when he developed a head cold with nasal stuffiness, mild headache and slight cough productive of whitish phlegm. Subsequent to a game of golf four days prior to admission, he had noticed soreness in the lumbar region. One day prior to admission, fever with soreness and stiffness of the neck accompanied a severe headache. There were no GI symptoms aside from anorexia and transient nausea. Upon reporting on sick call he was immediately transferred to the above installation under suspicion of Polio. An Officer in his Battalion had likewise been admitted to another hospital 10 days previously for suspected Polio. The patient had experienced an attack of bronchial asthma at 11 years of age and pleurisy in February 1953 with 14 days hospitalization. These were the sole findings on system review.

Initial physical examination revealed an acutely ill patient with clear sensorium. Temperature was 101.8°F. The conjunctivae were moderately injected and the eyeballs slightly tender upon pressure. There was hyperemia of the nasal mucous-membranes with a serous discharge. The tonsils and pharynx were hyperemic. Marked nuchal rigidity and pain on flexion of the head forward or lateralward were present. The lungs were clear, and respiratory movements were free and equal. The heart had normal sinus rhythm with no thrills, murmurs or arrhythmias. Blood pressure 130/112, Pulse 120, Respiration 20. The liver and spleen were not palpable.

On neurological examination the cranial nerves were intact. All superficial and deep tendon reflexes were present and equal, but hyperactive. Muscle strength was well preserved in the upper and lower extremities. The Kernig was slightly positive. The Brudzinski was 3 plus. Bladder function was good. W.B.C. 13,800 with 74 Neutrophils, 23 Lymphocytes, 2 Monocytes, 1 Eosinophile. R.B.C. 5,000,000 with Hemoglobin 15 Gm%. The spinal fluid appeared grossly granular and contained 188 cells with 64 Polys and 36 Lymphs. Glucose 68 mgm%; Chlorides 737 mgm%. Smear showed no bacteria. Urinalysis was negative. An admission x-ray showed the lung fields to be clear. Penicillin 600,000 units every 8 hours and Sulfadiazine 1 Gm. every 4 hours with adequate intra-venous fluids were begun.

During the next 24 hours, the disease progressed as an acute ascending spino-bulbar polio. Loss of the right knee jerk and weakness of the right leg were first noted, followed by atony of the bladder. Weakness then developed in the left leg. The right cremasteric and all superficial abdominal reflexes disappeared. The lower intercostal muscles lost their function. Difficulty in swallowing then ensued and cough reflex was lost. Thirty hours after admission, the intercostal muscles were completely paralyzed, so that only the diaphragm was functioning thereby maintaining shallow but regular respiration. The patient became aware of his respiratory difficulty and tired rapidly. A considerable quantity of mucous was accumulating in the mouth associated with very weak cough reflex. Immediate bedside tracheotomy was indicated.

After preparing the neck and chest with soap, water and merthiolate, 2% Procaine was injected along the midline of the neck from the thyroid cartilage to the supra sternal notch, superficially and deeply. A midline incision was made extending from the thyroid cartilage inferiorly, the distance of an inch. The strap muscles and soft tissues of the neck were dissected bluntly with a scissor and retracted with Pillar retractors. The dissection was carried down to the 2nd and 3rd tracheal ring. An incision was made through the 2nd tracheal ring, the tracheal ring was separated with a Kelly and a #5 Tracheotomy tube was inserted. One half-inch vaseline ribbon gauze was packed around the tube to produce hemostasis and prevent emphysema. Sterile gauze was applied over the incision and suction was applied to maintain a clean airway.

Following tracheotomy the patient volunteered that he had become much more comfortable. Aspiration through the tracheotomy indicated a clear tracheo-bronchial tree. It was now possible to keep the lung free of mucous accumulation being produced by marked salivation, tracheo-bronchial stasis, and inability to swallow. Following tracheotomy, the patient was placed in a mechanical respirator.

Temperature continued from 101°F. to 103°F. The soft palate on the right became paralyzed; however, reflexes and strength in the upper extremities remained good. Intravenous fluid administration was based on aberrations of the blood chemistry. Especial attention was focused upon CO₂ determinations. Urinary output was good, and on the morning of the fourth day the lungs were still clear, with only minimal secretions being aspirated through the tracheostomy.

On the sixth day atelectasis of the right upper lobe occurred, associated with no movement of the right

chest. The mediastinum shifted to the right, with cardiac pulsations noted on the right side. Aspiration, with a tracheo-bronchial lavage of normal saline solution, produced a moderate amount of thick whitish secretion. However, respiratory movements on the right side did not return. A bedside bronchoscopy was done with a 5 x 35 bronchoscope introduced through the tracheostomy, using normal saline to loosen mucous. Following the bronchoscopy, there was a minimal return of excursion of the right diaphragm.

Bedside x-ray examination of the chest showed elevation of the right diaphragm with a tracheal shift to the right. The right upper lobe was opaque. The right middle and lower lobes were clear. Bronchoscopy was repeated five hours later, with aspiration of thick whitish material. Six hours later, another bronchoscopy was performed, using a flexible curved tip aspirator. A vaporizer was installed. The patient was given oxygen by catheter in the tracheostomy opening and appeared comfortable. On the seventh day, a bronchoscopy was performed and aspiration of the right upper lobe resulted in clearing of the right upper lobe bronchus.

Following each bronchoscopy, a clean tracheotomy tube (#5) was reintroduced. There was a minimal amount of secretion aspirated from both main stem bronchi. Examination of the patient, with the mechanical respirator at rest, failed to show any intercostal or abdominal movement and only a faint suggestion of diaphragmatic motion. Periodic aspirations of the lung were done with a rubber catheter introduced throughout the tracheostomy, to prevent atelectasis.

On the ninth day respirations were good and equal bilaterally. The pulse rate was 120 to 130. Bronchoscopic aspirations of the right main stem bronchus produced a minimal amount of whitish mucous. On the tenth day, oral feedings were begun through a Levine tube. Examination of the pharynx and larynx showed a diffuse hyperemia of the mucous-membranes with normal motion of the vocal cords. On the eleventh day the neurological findings were unchanged. On bronchoscopy there was a minimal amount of secretion aspirated. The mucous membrane of the tracheo-bronchial tree remained diffusely hyperemic, probably due to the mechanical forcing of dry air into the lung. On the thirteenth day a bedside x-ray of the chest showed the lung fields to be clear, and he appeared to be stabilized. On the eleventh day he remained out of the mechanical respirator for 2 minutes, on the twelfth day for 3 minutes and on the thirteenth day for 4½ minutes. There was improvement in motion of the diaphragm and some intercostal movement on the left side. The patient began

receiving physical-therapy with passive muscle massage. On the eighteenth day he was able to breath for 7 minutes 45 seconds outside the mechanical respirator. The gag reflex became more active and there appeared daily improvement in muscle tone. A bronchoscopy was done on the twentieth day because of the presence of coarse palpatory rhonchi in the right upper chest. Thick mucoid material was aspirated. On the twenty-first day a repeat bronchoscopy was done with clearing of the chest. Massage and passive exercises were continued daily and the patient remained out of the respirator three times daily. Since the hospital was not equipped for long-term therapy and the patient had stabilized, he was evacuated to the United States for rehabilitation.

SUMMARY AND CONCLUSIONS

In bulbospinal poliomyelitis, the tracheo bronchial tree must be kept free of secretions to reduce anoxia and to prevent atelectasis and secondary infection. Tracheotomy and aspiration are usually adequate to keep the tree dry. Supplementary bronchoscopic aspiration through the 'ostomy may have to be done when atelectasis develops in spite of tracheotomy and suction. Both procedures should be initiated promptly when indicated.

Phoenix, Maryland

EISENHOWER PROMISES TO PRESS FOR REINSURANCE PLAN NEXT CONGRESS

The AMA Washington Letter, No. 86

President Eisenhower, speaking in a nation-wide radio-television program three days after the 83rd Congress adjourned, promised anew to press for his reinsurance plan in the next Congress. The following day, in vetoing a federal workers pay raise bill, the President also stressed the need for increased medical care for military dependents. Meanwhile, various agencies are working on legislative proposals to broaden fringe benefits, such as health insurance, for federal employees both in the United States and abroad. The 84th Congress convenes on January 5. The President's comments on:

Reinsurance: "We are at the midmark . . . We are going to get lots of things that have not yet been done . . . Health reinsurance we are going to put before the Congress again because we must have a means open to every American family so that they can insure themselves cheaply against the possibility of catastrophe in the medical line."

Dependent medical care: "These patriotic men and women, whose morale, skill, and dedication to service are so important to us all, now lack adequate medical care for dependents and reasonable survivorship benefits for their families. It is most important that these needs of armed forces personnel, serving their country often in remote corners of the world, engage our serious consideration."

ARTICLES OF INTEREST

MARRIAGE COUNSELING SERVICE, INC., NOW AVAILABLE IN BALTIMORE*

In 1946, the Baltimore Council of Social Agencies, acting in response to community recognition of an unmet need, made a study of existing agencies handling marriage problems and reported a need for additional services. Previous to this study there had been attempts by some groups to fill this need for counseling services, but none of these succeeded in establishing a stable organization. During this period, however, an increasing number of professional people, doctors, lawyers, clergymen, and others—those to whom people turn with their troubles—had become aware of the need. Laymen also have realized, through numerous articles appearing in the press and in popular magazines, that marriage counseling is desirable and useful.

Some marriage counseling services have been offered by the family welfare agencies, but these have been limited chiefly by virtue of the fact that such counseling is a secondary function of these agencies. It was this fact which led the Council of Social Agencies to recommend the establishment of a new agency with marriage counseling as its primary objective.

Marriage Counseling Service, Inc. was formed by a group of interested citizens to meet this recommendation and the obvious needs of the community in so far as it is possible to do this within the limits of its financial resources. The agency is financed in large part by contributions and to a small extent by moderate fees scaled to income. Its purpose is to help men and women achieve a greater understanding of marriage and to enrich the satisfactions they derive from the relationship.

The counselor is trained particularly in sociology and welfare work. At present this training is an integral part of the University of Pennsylvania, and internes are assigned for a definite time to this agency. The staff is professionally trained in marriage counseling and works under the supervision of medical and legal advisory committees. Pre-marital as well as post-marital counseling is available. The medical advisory committee sets the policies for relationships with referring physicians and a similar advisory committee reviews policies for collaborating with lawyers. Both committees are dedicated to maintaining the highest ethical relationships with the two professions concerned.

The agency especially welcomes referrals from physicians and will work in close cooperation with them whenever indicated. It prefers to have clients make their own appointments in advance—by telephone or letter—since this step is in fact the beginning of the counseling process.

If additional information is desired, write to the Marriage Counseling Service, Inc., Room 408, Latrobe Building, 2 East Read Street, Baltimore 2, Maryland.

* Authors: Dr. Paul V. Lemkau, Chairman, Medical Advisory Committee; Dr. Jacob Finesinger; Dr. Ralph G. Hills; Dr. James McCosh, Jr.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

Dr. Benedict Skitarelic, of Cumberland, was guest speaker at a banquet honoring the 1954 Graduating Class of nurses of the Sacred Heart Hospital; which was held at the Ali Ghan Shrine Country Club on August 26.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

The Baltimore City Medical Society, Executive Committee, and Executive Board are back from various vacations. The first official news comes from Executive meetings 18 September.

The Executive *Committee* took up membership problems, and, in relation to active and associate membership status, arrived at a working definition: The term "professionally active" is to mean any physician "practicing the profession of medicine" without other qualifying distinction as to practice. In considering applications for transfer and/or change in status that come up frequently, this basic definition will be a useful yardstick.

The Executive *Board* at the May session had voted to oppose State control of hospital laboratories through licensing of technicians. This is in line with the position of the College of American Pathologists (A.F.Cl. Path. 24:204. Feb. '54) and the recommendation of the Section on Pathology of the City Society.

In May, also, a billing system for the collection of professional fees similar to that of the Baltimore County Medical Association was presented by Messrs. Wells, Bailey, and Stoddart. The Board approved the system.

The Executive *Board* also approved a term Insurance plan. This is term insurance at a nominal cost to members—the premiums to be collected by the City Society. At the recent September meeting, certain "fine print" limitations to this insurance were

discussed. To be circularized to the Society are its non-convertibility during active membership, voiding during military service, and variability of rate according to underwriter experience as the plan progresses.

Blood bank problems were aired in the September meeting. This was brought up because of the difficulties the Veteran's Hospitals have in obtaining blood from friends and relatives of patients. The Red Cross National Blood Program presents administrative hurdles so that at present only seven counties in this State participate. Messrs. Ogden and Bain, Red Cross representative, stated that 2000 pints of blood had to be brought into Maryland during the past year. Dr. Milton Sacks, representing the Medical and Chirurgical Faculty's Blood Bank Advisory Committee, reviewed objections to the Red Cross Blood collecting policies of the past six years. One chief objection is the dependence of hospitals on the Red Cross once a hospital has closed its own Bank. The recommendations of the Blood Bank Advisory Committee were accepted and the Red Cross plan declined by the Executive *Board*.

BALTIMORE COUNTY MEDICAL ASSOCIATION

WILLIAM A. PILLSBURY, M.D.

Journal Representative

Dr. Samuel P. Scalia recently entered the United States Navy. Dr. Scalia practiced general medicine in Pikesville and was the *Journal Representative* and handled public relations for the Association.

Dr. Maxwell Sugerman, Reisterstown, died during the latter part of August.

CARROLL COUNTY MEDICAL SOCIETY

WILLIAM L. STEWART, M.D.

Journal Representative

A meeting of the Carroll County Medical Society was held at the Hoffman Inn, Westminster, on September 15, 1954. Twenty member and two guests were present.

Mr. Burton Parks, executive director of the

Arthritis and Rheumatism Foundation, explained the purposes and functions of his organization and showed how the Foundation is endeavoring to be of aid to the physicians in our county as a consulting service.

Dr. Gross from Sykesville delivered a brief eulogy in memory of Dr. Virginia Beyer who was for many years associated with the Springfield State Hospital. Dr. Culwell as President expressed the heartfelt sorrow of the entire Society on losing such a beloved member.

Our guest speaker was Dr. John Miller from Baltimore. He gave us a very interesting talk on the surgical diseases of the chest and the importance of their early recognition, diagnosis, and treatment. His talk was well illustrated by a series of slides.

HARFORD COUNTY MEDICAL SOCIETY

FREDERICK J. HATEM, M.D.

Journal Representative

The annual Crab Feast of the Society was held at Gabler's Shore on Bush River on Saturday, August 21, 1954. No business was transacted.

Those present were: Dr. Robert Barthel, Dr. Charles J. Foley, Dr. and Mrs. Brown McDonald, Dr. Peter P. Rodman, Dr. Alexander Sandecki, Dr. and Mrs. William Brendle, Dr. and Mrs. Ross Pierpont, Dr. and Mrs. Ralph Horky, Dr. and Mrs. Philip Heuman, Dr. James McC. Finney, and Dr. Frederick J. Hatem.

WICOMICO COUNTY MEDICAL SOCIETY

STEDMAN W. SMITH, M.D.

Journal Representative

Wicomico County Medical Society was shocked by the death of two of its older members within a few hours of each other—Dr. Hunter R. Mann, 65, died September 7th, and Dr. Lee Albert Rademaker, 51, September 8th.

Dr. Mann had just returned to active practice after a heart attack. He had been in practice here for 34 years, after service in the Armed Forces Medical Corps during World War I. He was born in Danville, Virginia, graduated from the University of Virginia, and he interned at St. Lukes Hospital in Bethlehem, Pennsylvania.

Dr. Rademaker was born in Tacoma, Washington and graduated from the University of Pennsylvania in 1928. He started his practice in Salisbury in 1932 after completing a fellowship in surgery at the University of Pennsylvania Hospital, Philadelphia, Pennsylvania. Dr. Rademaker was a member of A.M.A., Wicomico County Medical Society, Maryland Medical and Chirurgical Faculty, M.F.A.C.S., F.I.C.S. and F.A.P.H.S.

Dr. Rademaker died in Chicago where he had gone to attend a meeting of the International College of Surgeons, at which he was to be named a Regent of the College.

AMA REPLIES TO AMERICAN LEGION ON VETERAN MEDICAL CARE

The AMA Washington Letter, No. 87

The American Medical Association, replying to American Legion criticism of the Association's stand on non-service-connected care, reaffirms its support of federal responsibility for veterans with service-connected disabilities, but again calls for a halt to non-service care. The Legion opened an attack at its national convention in Washington. At a pre-convention session, *Robert M. McCurday*, chairman of the Legion's National Rehabilitation Commission, declared that the time had come "to kick them (the AMA) in the teeth." Two days later National Commander *Arthur J. Connell*, in his annual report to the members, declared that in the field of rehabilitation the Legion had wrested the initiative from "those who would destroy the present structure of medical and hospital care . . . We did this not by calling names and hurling threats but by giving the American people the facts."

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

HERNIAE

LOUIS KRAUSE, M.D.*

The story of herniae undoubtedly goes back to earliest man. Folklore of most primitive peoples indicates ritualism and procedures for the cure of herniae. The old European superstition of passing a child with a hernia through a forked trunk ash tree gives evidence of the antiquity of herniae. The mummies of ancient Egypt suggest certainly the frequent presence of herniae. Ever so often a large scrotum is found that bears silent witness to herniae of large size in life. How early surgery was suggested escapes us; nevertheless, efforts were made in the pre-Christian era for its cure. The literary remains from the immediate post-Christian era by Paul of Aeginae—ca 650 A.D. describe in detail the surgical procedure of the then accepted herniotomy. At that time it was customary to remove the testes at the time of operation. Even before this time the doctors differentiated clinically the hernia from hydrocele and epiplocele, etc. It was also known that obstruction or strangulation of hernia could occur. No improvement in the operative procedures were made until many centuries later. The modern era, of course, begins in the latter portion of the last century and up to the present time. The story of herniae, its recognition and treatment, can be traced in the following list of books:


HERNIA

- Guy de Chauliac. *Le maistre en chirurgie ou l'abrege complet de la chirurgie de Guy de Chauliac*. Paris, Hourt, 1744.
- Meckel, J. F. *Tractatus de morbo hernioso congenito singulari & complicato feliciter curato*. Berolini, Nicolai, 1772.
- Pott, P. *A treatise on ruptures*. In *The chirurgical works of Percival Pott*. London, Hawes, 1775.
- Geoghegan, E. *Commentary on the treatment of ruptures, particularly in a state of strangulation*. London, Highley, 1810.
- Lawrence, W. *A treatise on ruptures, containing an anatomical description of each species*. 1st. Am.

from the London corrected ed. Philadelphia, Parker, 1811.

- Scarpa, A. *Traité pratique des hernies, ou mémoires anatomiques et chirurgicaux sur ces maladies...* traduits de l'Italien par M. Cayol. On y a joint une note de M. Laennec... sur une nouvelle espèce de hernie; et un mémoire sur une terminaison particulière de la gangrene dans les hernies, par le traducteur. Paris, Gabon, 1812.
- Anderson, W. *System of surgical anatomy. On the structure of the groin, pelvis and perineum, as connected with inguinal and femoral hernia*. N. Y., Seaman, 1822.
- Cooper, A. P. *The anatomy and surgical treatment of abdominal hernia*. 2d. ed. by C. Aston Key. London, Longman, 1827.
- Stephens, H. *Treatise on obstructed and inflamed hernia*. London, Cox, 1829.
- Key, C. A. *A memoir on the advantages and practicability of dividing the stricture in strangulated hernia on the outside of the sac*. London, Longman, 1833.
- Parrish, J. *Practical observations on strangulated hernia, and some of the diseases of the urinary organs*. Philadelphia, Key & Biddle, 1836.
- Teale, T. P. *A practical treatise on abdominal hernia*. London, Longman, 1846.
- James, J. H. *Practical observations on the operation for strangulated hernia*. London, Churchill, 1859.
- Warren, J. H. *Hernia, strangulated and reducible. With cure by subcutaneous injections, together with suggested methods for kelotomy*. Boston, Thomas, 1881.
- Halsted, W. S. *The radical cure of inguinal hernia in the male*. In *Surgical papers*, vol. 1. Baltimore, Johns Hopkins Press, 1924.
- Bloodgood, J. C. *Operations on 459 cases of hernia in the Johns Hopkins Hospital from June, 1889 to January, 1899*. Baltimore, Johns Hopkins Press. (Reprinted from the Johns Hopkins Hospital reports, vol. 7.)
- Marcy, H. O. *The anatomy and surgical treatment of hernia*. N. Y., Appleton, 1892.
- Moynihan, B. G. A. *On retro-peritoneal hernia*. London, Baillière, 1899.
- Eccles, W. M. *Hernia, its etiology, symptoms & treatment*. N. Y., Wood, 1900.

* Chairman, Library Committee.

- De Garmo, W. B. Mechanical treatment of abdominal hernia. Philadelphia, Lippincott, 1913.
- Cowell, E. M. Hernia and hernioplasty. N. Y., Hoeber, 1927.
- Rice, C. O. Injection treatment of hernia. Philadelphia, Davis, 1937.
- Riddle, P. Injection treatment of hernia, hydrocele, ganglion, hemorrhoids, prostate gland, angioma, varicocele, varicose veins, bursae, and joints. Philadelphia, Saunders, 1940.
- Iason, A. H. Hernia. Philadelphia, Blakiston, 1941.
- Mair, G. B. The surgery of abdominal hernia. Baltimore, Williams & Wilkins, 1948.
- Watson, L. F. Hernia. 3rd ed. St. Louis, Mosby, 1948.
- Zimmerman, L. M. Anatomy and surgery of hernia. Baltimore, Williams & Wilkins, 1953. 

LIBRARY CHATTER

MARY EMILY BERGE

Dr. Samuel Livingston recently presented the library with a copy of his new book, "The Diagnosis and Treatment of Convulsive Disorders in Children." Dr. Livingston is a member of the Baltimore City Medical Society and is physician-in-charge of the Johns Hopkins Hospital Epilepsy Clinic. His book, published by Thomas, is written from the viewpoint of the pediatrician, and includes a chapter on the social management of epilepsy by Dr. Francis F. Schwentker and one on the surgical treatment by Dr. A. Earl Walker.

We are also very grateful to the Heart Association of Maryland for a copy of the "Proceedings of the Annual Meeting of the Council for High Blood Pressure Research of the American Heart Association." The meeting was held in Cleveland, Ohio, on May 15th and 16th, 1953.

Another conference report which should be of interest to internists and general practitioners is "Growing in the Older Years" published by the University of Michigan press. This is an outcome of the Third Annual Conference on Aging, held at the University in 1950, and emphasizes mental health, physical health, and education for an aging population.

"The Unique Influence of The Johns Hopkins

University on American Medicine" is the title of a brief essay by Richard H. Shryock, director of the Institute of Medicine at Hopkins, now available in the Faculty Library.

"Clinical Endocrinology" by K. E. Paschis, A. E. Rakoff, and Abraham Cantarow, published by Hoeber this year, is an extremely useful book on the subject and should be very helpful to the family physician as well as the specialist. For those who do not need such comprehensive treatment, "Hormones in Health and Disease," edited by Robert L. Craig and published by Macmillan, should fill the bill.

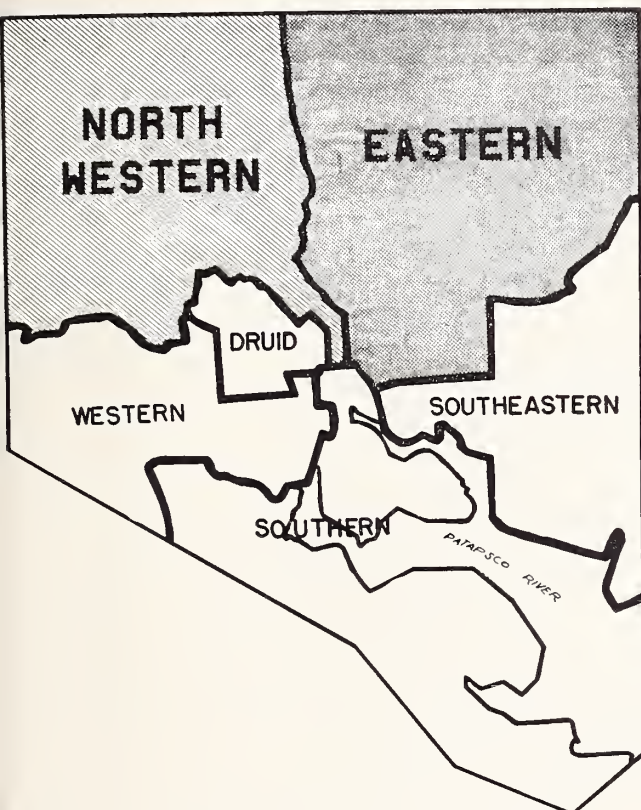
For students of medical history and bibliophiles, John F. Fulton's new book, "Michael Servetus, Humanist and Martyr," will be of particular interest. This includes a bibliography of his works and census of known copies by Madeline E. Stanton, librarian of historical collections in the Yale Medical Library.

The new biography of Virchow by E. H. Ackernknecht, "Rudolph Virchow: Doctor, Statesman, Anthropologist," presents the many-faceted personality of this amazing man.

Dr. Stephen Rothman's book, "Physiology and Biochemistry of the Skin," is another recent addition to the library. "Both as a definitive reference work and as a stimulant to further research, it is unique."

A number of old friends in the field of medical literature have recently appeared with new faces. After almost twenty years a second edition of "Legal Medicine, Pathology and Toxicology," by Gonzales and others, has come out. Long a standard work, this new edition by the former chief medical examiner of the City of New York and his colleagues will soon be practically indispensable. The Ormsby and Montgomery textbook on "Diseases of the Skin" is now available in a 1954 edition, the eighth, as is Lever's "Histopathology of the Skin," the second edition. There is a second edition also of the "Diet Manual of the Mayo Clinic" and one of "The Pathology of Trauma," by A. R. Moritz. "Diseases of the Digestive System," edited by S. A. Portis has come out in a third edition. Dr. Moses Paulson, a member of the Baltimore City Medical Society is one of the contributors to this volume. Any of these titles may be borrowed from the library.

Health Departments



Baltimore's Health District Boundaries—1954

BALTIMORE CITY HEALTH DEPARTMENT

Health District Boundary Changes

On September 1, 1954, new boundaries became effective for the Eastern and Northwestern Health Districts, chiefly as a result of the enlargement of the

Eastern Health District and the near completion of the newly constructed building for that district at 620 North Caroline Street. Comparing the accompanying map with prior health district maps, it will be seen that the Northern (north central) Health District has been disestablished. Half of it has gone to the Eastern Health District and half to the Northwestern Health District. It is planned, when a new Western Health District building becomes available, to make the Northwestern Health District a part of the Western Health District.

The 1953 population figures and the census tracts for the Eastern Health District and the Northwestern Health District as shown on the current map, are as follows:

Eastern Health District. Population: 333,100.

Census Tracts: Census Tracts 1 and 2 of Ward 5; all of Wards 6, 7, 8, 9, 10 and 12; Census Tract 1 of Ward 11, Census Tracts 1, 2 and 3 of Ward 26; and Census Tracts 1-12, inclusive, of Ward 27.

Northwestern Health District. Population: 190,640.

Census Tracts: Census Tract 4 of Ward 11; Census Tracts 1, 2, 4, 5, 6, 7, 8, of Ward 13; Census Tract 1 of Ward 14; Census Tracts 5-13, inclusive, of Ward 15; Census Tract 7 of Ward 16; Census Tracts 13-20, inclusive, of Ward 27 and Census Tracts 1, 2 and 3 of Ward 28.

Huntington Williams, M.D.

Commissioner of Health

* * * * *

THE NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

The National Foundation for Infantile Paralysis announces the availability of a limited number of clinical fellowships in the fields of physical medicine and rehabilitation. These are offered to physicians who wish to become eligible for certification by the American Board of Physical Medicine and Rehabilitation.

For further information and application blanks address: The National Foundation for Infantile Paralysis, Division of Professional Education, 120 Broadway, New York 5, New York.

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, October 1-28, 1954

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County.....	10	—	—	1	—	1	8	14	5	—	6	—	—	13	24	—	15	—	2
Anne Arundel.....	—	—	—	1	9	—	1	3	—	—	—	—	—	—	6	1	5	—	2
Howard.....	1	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	1	b-1	—
Harford.....	7	—	1	2	—	—	3	—	1	—	1	—	—	—	1	—	—	e-1	1
Carroll.....	—	—	—	1	—	—	—	1	—	—	—	—	—	—	2	—	—	—	—
Frederick.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—
Washington.....	—	—	—	—	—	—	—	2	2	1	—	—	—	1	4	—	4	—	—
Allegany.....	—	—	—	—	—	—	—	2	—	—	—	—	—	2	3	—	8	—	—
Garrett.....	—	—	—	1	1	—	—	—	—	—	1	—	1	—	—	—	4	—	—
Montgomery.....	—	—	—	4	9	1	6	8	2	—	2	—	—	—	7	—	7	—	2
Prince George's.....	2	—	—	1	2	—	2	3	4	—	3	—	—	—	2	—	6	—	1
Calvert.....	—	—	—	1	—	—	—	—	—	—	—	—	—	—	1	—	—	—	4
Charles.....	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	1	—	1
Saint Mary's.....	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—	—	—	—
Cecil.....	—	1	—	—	—	—	—	1	—	1	1	—	—	—	1	—	—	t-1	3
Kent.....	3	—	—	—	—	—	1	1	—	—	—	—	—	1	—	—	—	—	2
Queen Anne's.....	—	—	—	—	—	—	—	1	—	—	—	—	—	2	1	—	—	—	—
Caroline.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—
Talbot.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	3	—	1
Dorchester.....	—	—	—	—	—	—	—	3	—	—	—	—	—	—	1	1	2	—	1
Wicomico.....	—	1	—	—	—	—	2	—	—	—	—	—	—	—	1	—	7	—	—
Worcester.....	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	1	—	2
Somerset.....	—	—	—	—	—	—	4	—	—	—	—	—	—	—	2	—	—	—	—
Total Counties.....	23	2	1	12	21	2	28	41	14	2	14	0	1	22	58	2	68		22
Baltimore City.....	10	0	1	2	7	1	18	6	7	0	13	2	0	41	105	9	649	c-1	19
State																			
Oct. 1-28, 1954.....	33	2	2	14	28	3	46	47	21	2	27	2	1	63	163	11	717		41
Same period 1953.....	48	1	13	33	61	6	78	54	21	1	34	5	1	40	152	20	623		31
5-year median.....	34	2	5	—	31	2	40	104		2	38	3	3	52	189	37	662		31
Cumulative totals																			
State																			
Year 1954 to date....	3023	15	298	719	11392	30	2758	133	83	21	1328	17	6	761	1830	143	7463		426
Same period 1953.....	2744	11	1439	429	1550	66	2322	275	201	24	2222	29	10	336	1957	131	6779		605
5-year median.....	3077	24	949	—	4223	46	1571	337		55	923	27	34	514	2303	356	6347		479

b = botulism.
c = congenital syphilis under 1 year.
e = encephalitis, infectious.
t = tetanus.



Blue Cross - Blue Shield



BLUE CROSS IS REASONABLE

R. H. DABNEY*

When we say that ninety cents out of every subscription dollar goes to provide hospital care benefits, we simply testify that the Blue Cross dollar is hard at work. That's a tremendous return on any insurance dollar. And when we multiply it out, we find that total benefits paid were \$11.3 million in the year 1953, and already \$8.5 million in the first eight months of 1954.

There is no question that Blue Cross membership, dollarwise, is reasonable. But the financial reports and statistical summaries, important as they are, do not tell the whole story. They do not completely justify the widespread acceptance Blue Cross has today, or why this non-profit, community program has endured so long and so well. The answer, at least in part, lies in the *reasonable* approach to subscribers in terms of services—no less important really than the actual hospital benefits provided.

Though necessarily guided by basic insurance principles, Blue Cross does many things which are not considered sound insurance practice, but which nevertheless are good for the community and which reflect a reasonable approach to the community health problem. These things, aside from dollars charged and the dollars paid out, set Blue Cross apart.

For example, membership is basically voluntary without the requirement of management participation in cost which is characteristic of most commercial health insurance. Although many companies do now share in the Blue Cross subscription cost for their employees, our membership is still largely on a voluntary basis, available to any employed group that meets our enrollment requirements. And these requirements themselves reflect the community nature of Blue Cross—groups as small as five persons may enroll and only a 50% participation is needed for the larger groups. And members in any group, large and small, pay the same subscription rates for the same benefits.

We like to call our subscription rates community rates, as opposed to the experience rates used by commercial insurers. And therein lies a long-debated issue, too complex to discuss here. But therein also

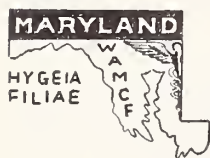
lies a fundamental principle of Blue Cross—charging a single rate to all persons in the community so that the risk is spread over the whole community. Obviously, some groups use more hospital care than others—type of occupation, average age, and sex distribution all make a tremendous difference, and are reflected in insurance rates to individual groups. They are all averaged out in the Blue Cross community rate.

Another factor, tied to dollars, is the Blue Cross policy of no commissions, no agent fees, no bonuses. All employees, from the office boy to the director—and including the sales force—are paid a salary. Health insurance today is competitive, and in a competitive field, vigorous selling is essential. Accepted business practice would seem to call for some financial incentive for the sales force at least, that is, commissions, fees or bonuses. Yet Blue Cross now has some 870,000 subscribers in Maryland who have memberships in groups which salaried representatives have secured without such dollar incentives. Blue Cross has always stuck to its basic principles and will continue to, resulting in tremendous savings to the community. Overall administrative costs, including sales, billing and claims-handling, now require only six cents out of each subscription dollar, a figure seldom if ever matched anywhere in the entire insurance field.

Too often, an employee loses his health protection when he needs it most—when he leaves his job because of layoff, change of job, or retirement. This means that his family loses, too—if the insurer had provided coverage for his dependents in the first place. Under Blue Cross, the employee's protection—for himself and his family—is his to keep when he leaves his place of employment. And he may keep it as long as he likes, take it with him wherever he goes—to Podunk on a new job, or to Florida to retire.

These are just a few examples of the reasonable approach taken by Blue Cross which benefit all subscribers in so many ways and set Blue Cross apart. There are many more, some equally important to these mentioned. They all combine in a unique way to put Blue Cross as close to every human situation as an organization and a contract can be. Blue Cross is not perfect—much remains to be done in the way of both services and benefits, in meeting the changing social and economic pattern of community health care—but Blue Cross has laid a good foundation on which to build.

* Director, Maryland Hospital Service, Inc., Maryland Medical Service, Inc.



Woman's Auxiliary Medical and Chirurgical Faculty



MRS. JOHN G. BALL, *Auxiliary Editor*

SEMIANNUAL MEETING PRESIDENTIAL ADDRESS*

MRS. ALBERT E. GOLDSTEIN

In August I had the pleasure of being an invited guest at the Thirtieth Annual Convention of the Woman's Auxiliary to the West Virginia State Medical Association at White Sulphur Springs.

The meeting opened Thursday at 8 a.m. with the President's breakfast and continued through Saturday noon with an Executive Board Meeting.

Mrs. George Turner, our National President, was the honored guest and to work with her on a State level was very enjoyable and educational.

"Getting to Know the Members" was the slogan throughout the meeting.

I wondered if we were making an effort to know our Auxiliary members.

We are a young organization and still timid. Sometimes we do not realize it but we seem afraid to get acquainted.

This year let us create friendly relations within our group and our Auxiliary purpose will not be defeated.

The Doctors' wives are the Auxiliary, and every member should feel the responsibility to create a friendly relationship throughout the organization.

Washington County has 100 per cent membership record. A record of which to be proud. That has been made possible through good public relations within the Auxiliary.

Many Auxiliaries in West Virginia's twenty-four organized counties, have limited members due to the number of physicians. Some counties are limited to fifteen doctors.

The results in these small groups have been excellent and the comparison was made to a small workshop, "a place to get together, pool our ignorance, then talk about it, and in this way become educated."

* Hagerstown, September 30, 1954.

An auxiliary consisting of from thirty to eighty members is large enough to get the job done and small enough to know each other.

In a large organization it is so easy to pay dues, feel relieved of obligation, hide, and do nothing. "The longer we work with others the more we realize the people we never liked were the people we never knew."

At the National Convention in San Francisco, the Maryland Auxiliary was awarded a certificate of achievement for outstanding effort in behalf of the American Medical Education Foundation. The Baltimore Auxiliary made it possible for us to go beyond our quota in this worthy project.

Our National President emphasized A.M.E.F. It is just as essential that we succeed in this project as Nurse Recruitment, otherwise we would be putting the cart before the horse.

It will interest us to know that West Virginia gives all money left over from allocated funds to A.M.E.F. It would not be practical to expect every organized County in Maryland to promote the same projects. The need in your community guides you in making that decision.

There is need for Public Relations, Legislation and Program chairmen in all groups.

Today's Health, A.M.E.F. and the Bulletin are the only projects where it is necessary to sell ourselves for the cause and they are worth while. Today's Health is the only authentic health magazine published for lay people and the only contact between A.M.A. and the public.

A good chairman on a drive is a "person with conviction calling upon a person with money" so talk these projects up to yourself first, then go out and sell them.

I wish you a happy and successful year, and your President will try to be of service in some small way.

Please help me to know you better. When I know every member by her first name I will feel satisfied. Not until then.

A NEW PROJECT FOR THE AUXILIARY

When Mrs. Leo Schaefer made her final report to the Auxiliary at San Francisco, she said upon her retirement from Auxiliary office she would turn her attention to Highway Safety and "will work to save healthy life as well as diseased life." This declaration and the challenge that the Auxiliary take "Highway Safety" as a new project was undoubtedly the outgrowth of Mrs. Schaefer's attendance, together with 250 women representing state and national organizations, at the White House Conference on Highway Safety held February 18, 1954.

All citizens have a responsibility in dealing with the problems of traffic safety. Women have a special responsibility and opportunity working with their families in the home to create correct attitudes about traffic safety. Local community-wide citizen safety groups must be organized. They may consist of coordinating councils of representatives of existing organizations. The local community citizen group for traffic safety should be flexible and adapted to the needs of its respective community. An effort to use all available existing community resources should be made through its leadership. Interested individuals or influential groups are most successful in activating local traffic safety groups.

Participation of women in the initiation of a local traffic safety program might take one of three forms; (a) to cooperate with already existing traffic safety groups in accelerating the program; (b) to enlist leadership from individuals or organizations in es-

tablishing groups; (c) to initiate action and secure community support in establishing new traffic safety groups.

In order to develop a feeling of public consciousness about highway safety, national organizations could give endorsements, publicity and encourage state and local groups to take part in traffic safety programs, as the National Auxiliary has already done. The cooperation of public officials and media could be enlisted in giving publicity to public information programs.

The contribution women's groups could make on a local level are: voluntary leadership, enthusiasm and willingness to work cooperatively, realistic appraisal of existing local traffic laws to determine their adequacy, and to effectively enforce traffic safety laws.

In order to utilize and support the efforts of professional highway safety people, local groups can secure existing inventories to determine local traffic safety needs, secure help in planning a remedial program and in informing and educating local organizations.

In the last analysis any successful traffic safety program must be geared to the idea that safety is the responsibility of the individual. The three E's, Engineering, Enforcement, Education, cannot be relied on alone. In addition we need the three A's of individual responsibilities; Awareness of what I need to do, Acceptance of what I ought to do and Action for what I will do. (Partial condensation from the Report of the Women's Group of the White House Conference on Highway Safety.)

* * * * *

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Office of the Secretary—Robert L. Faulkner, M.D.
2105 Adelbert Road
Cleveland 6, Ohio

The next scheduled examination (Part I), written examination and review of case histories, for all candidates will be held in various cities of the United States, Canada, and military centers outside of continental United States, on Friday, February 4, 1955.

Case Abstracts numbering 20 are to be sent by the candidate to the Secretary as soon as possible after receiving notification of eligibility to the Part I written examination.

Candidates are reminded at this time that lists of hospital admissions must accompany new applications and requests for reopening.

Ancillary News

NURSING SECTION

THE AMERICAN NURSES' ASSOCIATION AND THE NATIONAL LEAGUE FOR NURSING*

A Joint Statement on Purposes and Functions

Submitted by the Maryland State Nurses Association, a constituent association of the American Nurses' Association, and the Maryland League for Nursing, a constituent association of the National League for Nursing

The American Nurses' Association and the National League for Nursing are separate organizations with a common objective—to provide the best possible nursing care for the American people.

Each organization has distinct purposes and functions:

PURPOSES

Through ANA, nurses work for the continuing improvement of professional practice, the economic and general welfare of nurses and the health needs of the American public.

In the NLN, nurses and friends of nursing of all races, creeds and national origins act together to provide the people of their communities with the best possible nursing services and to assure good nursing education.

FUNCTIONS AND SERVICES

ANA

Defines functions and promotes standards of professional nurse practice

Defines qualifications for practitioners of nursing, including those in various nursing specialties

Promotes legislation and speaks for nurses regarding legislative action for general health and welfare programs

Surveys periodically the nurse resources of the nation

Promotes the economic and general welfare of nurses

* Reprinted by courtesy of The American Nurses' Association and The National League for Nursing.

and works to eliminate discrimination against minority-group nurses in job opportunities

Provides professional counseling service to individual nurses and to employers in regard to employment opportunities and available personnel

Finances studies of nursing functions

Represents and serves as national spokesman for nurses with allied professional and governmental groups and with the public

Implements the international exchange of nurses program and assists displaced persons who are nurses

Serves as the official representative of American nurses in the International Council of Nurses

Works closely with the various State Boards of Nursing in the interpretation of nurse practice acts and the facilitation of interstate licensure by endorsement.

NLN

Defines standards for organized nursing services and education

Stimulates and assists communities, nursing services and educational institutions in achieving these standards through effective distribution, organization, administration and utilization of personnel

Promotes continual study and adjustments in nursing services and educational curricula to meet changing needs

Assists with or conducts community nursing surveys

Provides consultation, publications, cost analysis methods and data, and other services to individuals, nursing services, schools and communities

Conducts a national student nurse recruitment program cosponsored by the ANA, the American Hospital Association, the American Medical Association

Carries out and promotes studies and research related to organized nursing services and educational programs

Represents nursing services and nursing education

units with allied professional, governmental and international groups and with the public

Accredits educational programs in nursing

Offers comprehensive testing and guidance services to institutions with practical, basic or advanced nursing education programs

Provides, in cooperation with state licensing authorities, examinations and related services for use in licensing professional and practical nurses.

MEMBERSHIP

All ANA members are professional registered nurses, representing every occupational field of nursing. There are two types of members: Active and Associate (retired or inactive nurses).

NLN members are professional and practical nurses, men and women in allied professions, other people interested in good nursing, nursing service agencies—hospitals and public health—and institutions offering educational programs in nursing.

CONSTITUENT GROUPS

The ANA is a federation of 53 constituent associations including the 48 states, the District of Columbia, Puerto Rico, the Panama Canal Zone, Alaska and Hawaii. State Nurses Associations, in turn, usually are composed of constituent District Associations. ANA membership also is divided into district, state and national sections according to occupational specialties within nursing.

As of April 1954, NLN counted as affiliates 45 state Leagues for Nursing, the District of Columbia, Hawaii and Puerto Rico.

Many state Leagues are organizing constituents known as local Leagues for Nursing. A Council of State Leagues for Nursing, comprised of the president or alternate of each state League, NLN's officers and ANA's president, coordinates state programs and purposes with those of the National League for Nursing.

OPERATING PLAN

Members of state sections elect representatives to the ANA House of Delegates who, in turn, vote for the Board of Directors. ANA section executive committees are elected by section members attending the biennial conventions. Programs and policies of ANA are determined by the House of Delegates. The work of the ANA between conventions is furthered

through the activities of standing and special committees and the Board of Directors. A national headquarters with an administrative staff is maintained.

Every NLN member has a voice in the organization's policies and programs. The Board of Directors is elected by direct vote of all members. Four departments represent major fields of interest in nursing service and education. A steering committee, elected by department members, guides the staff in carrying out each department's program. Each department also has a Council of its Member Agencies. Interdivisional councils and committees represent cross-sections of special interest groups.

HISTORY

ANA was organized in 1896 as the Nurses Associated Alumnae of the United States and Canada. When the Association was incorporated in New York in 1901, it was no longer possible for Canadian nurses to be affiliated. The present name was adopted ten years later. In 1951 the National Association of Colored Graduate Nurses became integrated with ANA. A year later, in the structure reorganization of nursing groups, ANA took over some of the work (definition of functions and qualifications of individual practitioners) formerly carried by the National League of Nursing Education and the National Organization for Public Health Nursing, which were combined into NLN.

The NLN was formed in 1952 when three national nursing organizations and four national committees combined their programs and resources: National League of Nursing Education (founded 1893), National Organization for Public Health Nursing (1912), Association of Collegiate Schools of Nursing (1933); Joint Committee on Practical Nurses and Auxiliary Workers in Nursing Services (1945), Joint Committee on Careers in Nursing (1948), National Committee for the Improvement of Nursing Services (1949), and National Nursing Accrediting Service (1949).

MAGAZINES*

The American Journal of Nursing, founded in 1900, is the official magazine of the ANA.

NLN's official magazine is *Nursing Outlook*, founded in 1953. NLN also sponsors *Nursing Research*.

* These magazines are published by the American Journal of Nursing Co., 2 Park Avenue, New York 16, New York.

COORDINATING COUNCIL

The ANA and the NLN coordinate programs of common concern, and keep in touch with each other's work and with the activities of the National Student Nurse Association through a Coordinating Council, composed of their combined Boards of Directors.

STUDENT ORGANIZATION

The National Student Nurse Association was organized in 1953 by students from 43 states and the District of Columbia, under the guidance of ANA and NLN. One member each from the Boards of ANA and NLN serves on the Advisory Council of the student association.

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PHYSICIANS, AMA PRAISED FOR WORK WITH UNITED MINE WORKERS

The AMA Washington Letter, No. 87

In its annual report, the United Mine Workers Welfare and Retirement Fund praises the medical profession and AMA for their cooperation in the fund's hospital and medical care program. The report stated: "A constant and constructive relationship with the American Medical Association has been maintained by the executive medical officer (Dr. Warren F. Draper) of the fund through its Council on Medical Service, its Council on Industrial Health and joint committees . . . Through the interest and concern evidenced by these national leaders in the profession, invaluable measures have been taken to assist the area medical administrators in their tremendous task of improving medical services in their areas." For the year ending last June 30, the fund spent \$52.2 million on hospital and medical care for miners and their families.

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AMERICAN DIABETES ASSOCIATION

Member of Medical and Chirurgical Faculty Appointed

The Council of the American Diabetes Association has appointed Dr. J. Sheldon Eastland of Baltimore, Governor for the State of Maryland.

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FILM AVAILABLE FROM AMERICAN MEDICAL ASSOCIATION

To: Secretaries or Executive Secretaries, State Medical Societies

We are sending you a 35 mm film strip entitled "Your Future in the Professions—Doctors." This vocational guidance film was just produced by the Society for Visual Education, Inc., in cooperation with the AMA, and we think you might find it a valuable addition to your high school guidance and health education programs.

The film covers the necessary aptitude and preparation for a medical career, its opportunities and responsibilities, the various specialties, and the social and economic demands made both of the medical student and the practicing physician. The final sequence of the film lists several topics for discussion between the students and the physician presenting the program.

If you would like to recommend this film strip to your county societies, additional prints may be purchased at \$3.25 each from SVE at 1345 Diversey Parkway, Chicago, or from its representative in your area.

Coming Meetings

SECTION ON INTERNAL MEDICINE*

FRANCIS W. GLUCK, M.D., *Chairman*

ERNEST C. BROWN, JR., M.D., *Secretary*

Tuesday, December 14, 1954, 8:00 p.m.

Small Hall, Faculty Building

1211 Cathedral Street, Baltimore

CANCER SECTION*

HOWARD D. FISHBURN, M.D., *Chairman*

ARTHUR G. SIWINSKI, M.D., *Secretary*

Wednesday, December 15, 1954

U. S. Public Health Service Hospital, Wyman Park Drive

Dinner 6 p.m.

Scientific Session 8:00 p.m.

Scientific Session in Officers Club.

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and
Chirurgical Faculty.

RICHARD W. TELINDE, M.D., *Chairman*

BEVERLEY C. COMPTON, *Secretary*

Faculty Building, 1211 Cathedral Street, Baltimore

Thursday, December 16, 1954, 5:00 to 6:00 p.m.

MATERNAL MORTALITY COMMITTEE

HUNTINGTON WILLIAMS, M.D., *Chairman*

GEORGE H. DAVIS, M.D., *Acting Secretary*

Thursday, December 23, 1954, 4:00 to 5:00 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and Baltimore
City Health Department.

* Sections of the Baltimore City Medical Society

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WOMENS AUXILIARY MEDICAL AND CHIRURGICAL FACULTY ANNUAL MEETING

Thursday, April 21, 1955

Sheraton-Belvedere Hotel

The wives of all members of the Faculty are urged to plan to attend this meeting. Watch for more details
in the January Journal.

ARMY TAKING 100 PHYSICIANS, FIRST IN 16 MONTHS

The AMA Washington Letter, No. 86

Defense Department has asked Selective Service to call up 550 physicians under the doctor draft for assignments in December. One hundred are scheduled to go to the Army, the first since August, 1953. Defense said the Air Force requires 200 and the Navy, 250 physicians. The Department also requested 150 dentists, all for the Air Force.

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HEW WILL ASK \$200 MILLION MORE FOR FISCAL 1955

The AMA Washington Letter, No. 89

The 84th Congress convening in January will be asked to appropriate an additional \$200 million for Department of Health, Education, and Welfare programs during the current fiscal year. If granted, this would bring the HEW's fiscal 1955 spending for all social security, welfare, and health programs to \$1,942,000,000, according to the annual late summer review of the budget issued by Budget Director Rowland Hughes. He did not give a breakdown. Total spending by HEW this year, Mr. Hughes reported, will be about 1% above fiscal 1954 and 3% above fiscal 1953. Although \$31 million more is available than last year for both regular and clinic-center Hill-Burton programs, net expenditures should decline by \$5 million due to the time lag involved in developing the new state programs. In 1955, Veterans Administration will provide care for a greater number of hospital patients than in 1954.

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VA ADMINISTRATOR OUTLINES NEW PLAN FOR AGING VETERANS

The AMA Washington Letter, No. 87

Veterans Administrator Harvey Higley has outlined a new plan for federal care of the aged and chronically ill veteran to help solve a problem "that rapidly is becoming more acute." He made his proposals in an address to the American Legion national convention during which he also announced that the VA's program of constructing 174 new hospitals was near completion. Mr. Higley explained that special wings or wards could be set aside in general medical and surgical hospitals for treatment of diabetics, arthritics, amputees, pulmonary cripples, cardiacs, and patients with chronic neurological problems and some psychiatric cases. He also asked the veterans to contribute advice on (1) provision of enough money "in the very near future" for rebuilding, modernizing, and rehabilitating some VA hospitals, and (2) establishment of rehabilitation programs for veterans recovering from mental illnesses. He estimated 85,000 are receiving VA hospital or clinic care for mental disabilities and another 15,000 are on waiting lists for non-service-connected conditions.

MEDICAL ABSTRACT FROM:
James F. Fleming, M.D.
30 West Washington Street
Chicago 2, Illinois

THE DRUG OF CHOICE IN AMEBIASIS

—Dwork, K. G.: *Amer. J. Gastroenterol.* 22: 152 (Aug.) 1954.

The drugs that are in widest use in the treatment of amebiasis today are the following:

1. Antibiotics: Aureomycin, Terramycin and fumagillin
2. Iodoxyhydroxyquinolines: Diodoquin, Vioform and Chinofon
3. Arsenical: Carbarsone
4. Bismuth-arsenic: Milibis
5. 4-aminoquinoline: chloroquin
6. Alkaloid: emetine

The use of antibiotics began in 1949 when McVay and his colleagues discovered the usefulness of Aureomycin in amebiasis. At that time satisfactory but not total rates of cure had already been obtained with Carbarsone, Diodoquin, Vioform and Chinofon. The effectiveness of antibiotics cannot be denied, but their limitations are equally apparent to the critical observer. For example, most physicians have observed side effects which are sometimes severe and surprisingly persistent following discontinuance of the drug.

The initial enthusiasm following the results of short term study of these drugs was somewhat tempered as recurrences were detected among the patients followed for four or more months. With any drug used in treating amebiasis, a relapse rate of 10 to 20 per cent is usually found when cases are followed adequately.

The latest antiamebic product of the mold is fumagillin, which is amebicidal in vitro in extremely high dilution. It produces undesirable, although not serious, side effects, and the rate of cure is high, but not total.

How do the iodoxyhydroxyquinolines compare with the antibiotics? Out of 152 adult patients treated with Diodoquin by the author, 16 (11 per cent) showed positive stools at some time after treatment. Six of these 16 cases, however had inadequate doses of the drug. The cure rate with Diodoquin was, therefore, over 90 per cent in adults. Similar results were obtained with 57 children. The author's impression is that Diodoquin is the most dependable of these quinoline compounds, and that Vioform is somewhat more effective than Chinofon.

The choice in any given case should be dictated by such considerations as previous failure of a given amebicide, history of sensitivity, severity of symptoms, presence of hepatitis, necessity for rapidity of treatment, certainty of diagnosis, and the financial status of the patient.

In choosing a drug one should not prescribe any of the 'mycin' antibiotics for the patient who has a history of nausea, vomiting, diarrhea, abdominal pain, or anal pruritus following his previous use of that drug. For general use, Diodoquin is a good amebicide, and does not usually cause side effects. Milibis is a satisfactory general amebicide although the failure rate in children seems to be high. Treatment with Vioform results in a higher incidence of gastrointestinal symptoms. Fumagillin is a potent amebicide and its exact place in the scheme of treatment must await continued evaluation. Aureomycin and Terramycin are effective amebicides but their use is attended with a high incidence of undesirable side effects and they are expensive. Terramycin may be the more efficient of these two.

In broad perspective, perhaps most of the cases seen in this country will best be managed with a course of Diodoquin or Carbarsone. A certain number will do well on fumagillin, Terramycin or Aureomycin; or with penicillin or sulfasuxidine followed by Diodoquin in sicker patients; the seriously ill cases should be given emetine either before or concurrently with the standard amebicides.

For amebic hepatitis, chloroquin is employed. One of the standard drugs efficient against intestinal amebiasis should always be given concurrently or after completion of the course of chloroquin.

NATIONALS OF GERMANY MUST REGISTER WITH SELECTIVE SERVICE*

Major General Lewis B. Hershey, Director of Selective Service, has announced that all physicians, dentists and veterinarians who are nationals of Germany must register with Selective Service if they have been admitted to the United States for permanent residence. Even though they have not declared their intention of becoming citizens and might have previously been exempt from registration under the so-called "Doctor and Dentist Draft Act," they are now required to register, Hershey emphasized.

In the Proclamation (No. 2915), issued December 27, 1950, the President exempted from special registration under the so-called "Doctor and Dentist Draft Law" aliens who were residing in the United States, who had not declared their intention of becoming citizens and who were nationals of any country with which there was in effect a treaty or international agreement exempting its nationals from military service while they are within the United States. Germany was one of the 18 countries with whom we had such a treaty, General Hershey pointed out, so German doctors were not formerly required to register. That provision of the treaty with Germany relating to the reciprocal exemption from military service expired on June 2, 1954, General Hershey explained, so those doctors who had not yet reached their 50th birthday on January 15, 1951, must now present themselves to a local board and register as special registrants.

We still have treaties or International agreements with 17 countries which contain provisions for the reciprocal exemption from military service of each other's nationals while they are within the other's country. The countries are:

Argentina	El Salvador	Italy	Paraguay
Austria	Estonia	Latvia	Siam
Costa Rica	Honduras	Liberia	Spain
China	Ireland	Norway	Switzerland
			Yugoslavia

No estimate was available as to the number of German doctors who may become liable for service in our armed forces as a result of the expiration of the treaty provisions.

* * * *

AN INVITATION FROM THE INTERNATIONAL CONFERENCE ON ANIMAL VENOMS

The International Conference on Animal Venoms is being held in association with the annual meetings of the American Association for Advancement of Science, at Berkeley, California, December 26-31, 1954.

The zoological, chemical, pharmacological and therapeutic aspects of this broad subject will be covered, in more than 60 papers contributed by outstanding experts from all over the world.

Members of the Medical and Chirurgical Faculty are cordially invited to attend the Conference, which will open at 9:00 a.m., Monday, December 27, and close at 5:00 p.m., Thursday, December 30, and to participate in the panel discussion which will take place on the last afternoon. A program-directory, describing the meetings in sequence, is now in preparation by the Association, and details will be announced in Science and Scientific Monthly.

* Submitted by Colonel Henry C. Stanwood, Maryland State Headquarters, Selective Service System, Fifth Regiment Armory, Baltimore 1, Maryland.

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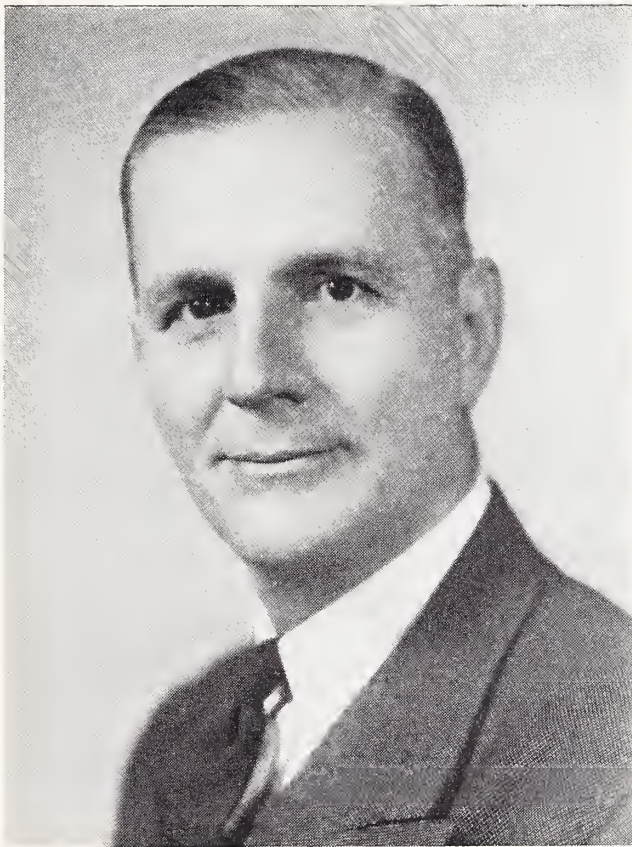
December, 1954

NUMBER 12

PRESIDENTIAL EDITORIAL

A REAL POSTGRADUATE NEED

BENDER B. KNEISLEY, M.D.*



BENDER B. KNEISLEY, M.D.

Today, more than ever before, practitioners of medicine see the need of postgraduate education. Also, more than in former years, a greater number of physicians are attending more postgraduate courses. The content of these courses vary, for the most part, from fair to excellent. With the exception of a few states, postgraduate education has been maintained with no particular idea of a well co-ordinated plan and certainly with not

* President, Medical and Chirurgical Faculty, 1954.

a too well united organizational effort of those agencies promoting postgraduate education. And here, we are not discussing the formal or fellowship graduate training but the postgraduate work of the busy physician in active practice. Postgraduate education of this latter type is a lifetime process for the physician. He must obtain his instruction in recent and current practices in his profession in compact form and at times and places that suit him best. Of course, many physicians get their postgraduate education by reading books and journals as well as in their association with colleagues and in staff conferences at hospitals. But even so, there is a strong trend today for postgraduate courses lasting one to several days, chiefly didactic in nature, although some men wish for a more participating type of instruction.

Here in Maryland we have different organizations promoting postgraduate programs for the physician. The Medical and Chirurgical Faculty has had, for many years, a Scientific Session at its Annual and Semiannual Meetings. The Maryland Chapter of the American Academy of General Practice in recent years has had several programs a year particularly pointed to the general practitioner. The Baltimore City Medical Society has put forth good effort in holding one night a week postgraduate programs during a certain period of the year. The University of Maryland Medical School and the Medical School of Johns Hopkins University have had postgraduate programs for the active practitioner at various times each year. Besides, there are Staff Conferences at the various Baltimore hospitals and other postgraduate schedules at those hospitals. All of which, one can say, are fine as far as present resources are concerned.

But with such a wealth of present assets in postgraduate medical education, there is a great need for administrative organization and direction in the field under discussion. A very modest start has been made in this direction by the establishment of a Central Registry at the Medical and Chirurgical Faculty office building. This was established by action of the House of Delegates at its recent Semiannual Meeting. The Registry will be administered jointly by the Faculty and the University of Maryland Medical School, and all members of the Faculty will receive at regular intervals bulletins of the future programs in postgraduate education.

At the last Semiannual Meeting the president was empowered by a motion of the House of Delegates to appoint a committee to explore, ascertain facts, and bring in recommendations at the next Annual Meeting on postgraduate instruction. The committee will look into program content; what is best suited for special groups and special areas; the overlapping of schedules; faculty usage; and how to get the best out of our present resources, the existing programs of postgraduate instruction. In addition, the committee will look into the evident need of executive direction of the over-all postgraduate program. Surely, no busy doctor today can do justice to such a responsibility. Also, postgraduate education and its administration costs money. Very often we appreciate better that for which we pay; and the cost, spread over the whole membership, would certainly be minimal.

The proposed Postgraduate Study Committee's personnel will be from the Medical and Chirurgical Faculty, the Baltimore City Medical Society, the Maryland Chapter of the American Academy of General Practice, the Medical School of The Johns Hopkins University, and the Medical School of the University of Maryland.

Let us hope that, as we give this postgraduate instruction more study, there may evolve a better promotion, a more stimulating effort, and real co-ordination with good executive direction for the efficient use of our very good resources in postgraduate education in Maryland.

Reports

MARYLAND PROJECT—CORNELL AUTOMOTIVE CRASH INJURY RESEARCH

The Maryland Project of the Automotive Crash Injury Research under the supervision of Cornell University Medical College, which has been operating in Prince George, Anne Arundel, Baltimore and Howard Counties, was extended on September 15 to include the areas of Kent, Queen Anne, Talbot, Caroline and Dorchester Counties. This important investigation of injury causing elements of pleasure automobile structure is carried on jointly by the Maryland State Police and the Medical and Chirurgical Faculty of the State of Maryland, under the direction of the research group of Cornell Medical College. The physicians and hospitals in the above Counties will be asked to cooperate in the same way as their neighbors in the four initial counties, who have done an extraordinary job during the time the study was inaugurated in Maryland in November of 1953. The project has been approved by the Council and the House of Delegates of the Medical and Chirurgical Faculty and Dr. Russell S. Fisher, Maryland Chief Medical Examiner and Colonel Elmer F. Munshower, Superintendent, Maryland State Police, have been cooperating in the Study. Cornell personnel engaged in Maryland are: Mr. Robert Tracy and Mr. Mike Macht.

This important and original research is being carried on simultaneously with the aid of state medical societies in Connecticut, North Carolina and Virginia, and a new program will soon get underway in Minnesota. In the study an entirely new viewpoint has evolved. It is recognized that, human nature being what it is, crashes will occur as long as vehicles are driven by human beings, but that it should be possible to make the inevitable accidents productive of fewer crippling or fatal injuries. To this end, highway accidents are analyzed with a view to learning how to build more safety factors into automobiles. Already some highly interesting findings have resulted and as the statistics increase, it is believed that recommendations for revision of details can be made in automobile design.

Physicians and highway police who have engaged in the study have found it stimulating and productive. It cannot be definitely stated how long the program will continue in the area of Kent, Queen Anne, Talbot, Caroline and Dorchester Counties. It will depend somewhat upon the type and frequency of accidents. Eventually data on a cross section of accident incidence on the highways of Maryland will be presented.

ANNUAL MEETING 1955

MEDICAL AND CHIRURGICAL FACULTY

Thursday, Friday, and Saturday, April 21, 22, and 23, 1955

Dr. Darrell Hart, Professor of Surgery at Duke University, has accepted the invitation of Dr. Edmond J. McDonnell, Chairman of the Committee on Scientific Work and Arrangements, to give the J. M. T. Finney Fund Lecture. The Committee has also secured Mr. Moore to speak on the highly interesting Automotive Crash Injury Research.

Room reservations for the 1955 Annual Meeting are now being accepted by the Sheraton-Belvedere Hotel.

Scientific Papers

CARDIOLOGY IN GENERAL PRACTICE

C. EDWARD LEACH, M.D.*

Cardiovascular problems challenge all of us in practice today. They have increased in frequency to the point at which they account for about half of the national death rate; more than the five next most common diseases combined. Thus, any type of practice must have its share of cardiac patients, but the nature of our responsibility to these patients is different and more demanding.

During the thirty-five years of cardiology as a clinical specialty, detailed studies have clarified the various clinical pictures for us. The main types of heart disease have become as familiar as typhoid fever used to be. It is rare now to mistake coronary thrombosis for acute indigestion, and the signs of rheumatic mitral stenosis are recognized early in the medical student's career. In fact, there is so little tendency to overlook these conditions that they are too frequently diagnosed even when they are not present. Let us say then, that we have gained an increased awareness of heart disease, of its clinical course, and its physical diagnosis, but there is more than that. Through specialized research we have learned much more about how the heart is affected by disease and how this alters physiology of the circulation and of the body as a whole. Available to us are many accessory aids to complete the clinical study of a given patient—the electrocardiogram and x-ray, including angiocardiology, for more accurate anatomical diagnosis; chemical analysis of blood electrolytes; and oxygen and pressure measurements by means of cardiac catheterization, to mention a few. Although of

little practical value now, vectorcardiograms and ballistocardiograms may help too after they have had further investigation. In respect to treatment, progress has been striking. We have seen syphilitic heart disease decline with better, early antiluetic therapy. Prophylactic treatment of streptococcal infections has begun to affect the incidence and course of rheumatic heart disease. Anticoagulants have improved the outlook for patients with various types of thrombotic episodes. We have improved forms of digitalis and more effective diuretics, as well as better drugs for treatment of arrhythmias and shock. Probably most dramatic in the therapeutic field has been the wider use of surgery. Its benefit has been outstanding in the correction of some congenital and rheumatic lesions and the field still seems to be expanding. Surgery also offers some benefit in conditions such as hypertensive disease and possibly carefully selected coronary cases, and, of course it is the chief means of relief for constrictive pericarditis and major peripheral emboli.

All of these benefits from research should change our whole attitude toward cardiovascular practice. No longer is it sufficient to make a general diagnosis and then sit back and hope that it will not progress too rapidly. Instead we have the means for an active attack on many serious heart conditions by which we can halt or alleviate the downhill course. To make full use of our opportunities it is necessary that our diagnosis be specific, that we have a good idea of the amount of functional impairment in each case, and that we recognize changes in the patient's status early enough to forestall serious complica-

* Asst. Prof. of Medicine, University of Maryland Medical School; Chief of Adult Cardiac Clinic, University Hospital; Chief of Cardiology, St. Agnes Hospital; Associate Cardiologist, Bon Secours Hospital.

tions. In view of the changing pattern it may be helpful to review some of the important aspects of cardiac practice today. It is not the intention here to present details of differential diagnosis and treatment but rather to point out briefly certain aspects of cardiac practice which merit careful consideration.

CONGENITAL HEART DISEASE

Although it accounts for less than 2% of heart disease, this group has become relatively important because of the relief afforded some cases by newer surgical techniques. Patent ductus arteriosus and coarctation of the aorta can be corrected surgically. Considerable relief can be expected from surgery in patients with aortic or pulmonic stenosis, Tetralogy of Fallot, and tricuspid stenosis or atresia. Early results in auricular septal defect seem promising. It is the medical man's job to find and evaluate the operable cases.

Patent ductus is usually identified easily by the characteristic continuous, machinery-like murmur to the left of the upper sternum. However, it may be present with only a systolic murmur. Diagnosis may then depend on x-ray demonstration of increased hilar pulsation and flow of opaque material from aorta to pulmonary artery plus catheterization evidence of increased pressure and high oxygen content in the pulmonary artery. Mild cases without symptoms or significant enlargement of the heart probably do not require surgery. Those with much limitation in exercise tolerance should have the defect corrected in childhood, if possible, in order to avoid prolonged heart strain.

Coarctation of the aorta is indicated when blood pressure is found to be elevated in the arms and much diminished in the legs. Apparently this part of the examination is frequently overlooked in childhood, since many cases of coarctation are first discovered in early adult life. In examining children it is a good idea to get in the habit of palpating for femoral pulsation and then checking carefully on blood pressures if the pulse is much diminished. Other helpful signs

of the defect are palpable intercostal artery pulsations, murmurs to the left of the spine, x-ray evidence of rib notching, small or absent aortic knob, and demonstration of the aortic defect by contrast x-ray study. It is probable that all cases with coarctation should be operated during childhood since the effects of this condition resemble those of severe acquired hypertensive disease.

Commonest of congenital defects with cyanosis is Tetralogy of Fallot. These patients usually show some degree of clubbing of the fingers and toes. There is increased pulsation over the lower sternal area with evidence of right ventricular hypertrophy and a loud, harsh, systolic murmur and thrill along the left sternal border. A high degree of right axis deviation is present in the electrocardiogram. In spite of the right ventricular enlargement, the pulmonary artery appears small by x-ray, and the lungs show less than the usual vascular shadows.

There is likely to be less cyanosis in pulmonic stenosis and auricular septal defect but physical signs may be very similar to those of the Tetralogy. Since a septal defect is present in tricuspid atresia, this condition may also show about the same physical findings. It is in these patients with cyanosis that we depend so much on accessory examinations for specific diagnosis. As in the Tetralogy, the electrocardiogram in auricular septal defect and pulmonic stenosis shows right axis deviation, while left axis deviation occurs in tricuspid atresia. Further differentiation can be made by visualization of the chambers, and some times the actual defect, by contrast x-ray or angiocardiograms. Added to these data the pressure and oxygen content measurements from the chambers by cardiac catheterization should confirm a specific diagnosis. In cases with slight auricular septal defect, cyanosis is not present, and the condition may be benign and not require any radical treatment. In the other cyanotic cases mentioned the effects are always serious enough to warrant surgery, and much relief can be expected. In fact, surgery now offers so much that we can view the congeni-

tal heart disease problem with definite optimism and look for even wider use of operative treatment.

RHEUMATIC HEART DISEASE

The greatest progress toward the control of rheumatic heart disease so far has been through the use of antibiotics. It has been known for some time that rheumatic fever was intimately connected with the occurrence of certain hemolytic streptococcal infections. Early treatment of these infections with drugs and antibiotics effective against streptococci seems to prevent the development of rheumatic fever. In like manner, recurrences of rheumatic fever can be greatly reduced in frequency by prophylactic use of these agents. Oral penicillin in doses of 300,000 to 400,000 units daily has been effective and toxic effects are rare. There is some evidence though that twice this dosage may be necessary in some cases to keep the throat culture free of hemolytic streptococci and guarantee complete protection. Since rheumatic recurrences are most likely in childhood and during the first five years after the initial attack, prophylactic treatment should be kept up for three to five years in children and for two or three years in adults. Greatest safety is achieved if treatment is continuous throughout the year. Such a program is fairly expensive with any of the antibiotics. Probably equal results can be attained with the less expensive sulfa drugs, but reactions are more frequent, and closer check is necessary on urine and blood to avoid toxic reactions.

It is important to re-emphasize certain aspects of the relationship between rheumatic heart disease and activity of the rheumatic process. In general the heart disease is progressive only during periods of rheumatic activity. On the other hand, the importance of the rheumatic fever is judged primarily by the degree of heart involvement. Heart disease occurs early in the course of rheumatic fever, and greater caution in handling the case should be observed when more heart involvement is present. Conversely, patients show-

ing relatively little in the heart during early active rheumatic fever are likely to have little in the way of residual impairment and may be allowed more rapid progress in exercise as rheumatism subsides.

We must keep in mind that rheumatic fever may be present for long periods below the level of obvious clinical symptoms and signs, and its presence must be inferred from general knowledge of its behavior and rather subtle changes in the status of the patient. This has been well proven by autopsy and biopsy findings of Aschoff bodies in patients long after there had been any clinical evidence of an active process. We can also recognize slight, gradual improvement in some patients continuing for months after laboratory tests have returned to normal. Too often the rheumatic patient is released from careful supervision soon after his acute illness has subsided. In such cases, if activities are resumed too soon, low grade, smoldering rheumatic fever may cause additional heart damage. It is important that exercise be kept to a minimum until all evidence of rheumatism has disappeared as judged by general well being, satisfactory weight status, stable temperature and pulse, lack of change in heart signs and electrocardiogram, and return of blood counts and sedimentation rate to normal values.

After a quiescent state has been reached, the rheumatic heart does not tend to change abruptly without the occurrence of further inflammatory damage. In cases with severe chronic heart disease the natural course is for failure to develop gradually as a result of prolonged strain. Therefore, any patient who suddenly or rapidly develops decompensation should be suspected of having an active rheumatic state. If the suspicion is supported by other data, such a patient requires a prolonged convalescent period after the failure is controlled. One should also consider the likelihood of rheumatic fever in the course of chronic rheumatic heart disease with the appearance of auricular fibrillation, auricular flutter, or paroxysmal tachycardia.

In the absence of any definite change in status the patient with chronic rheumatic heart disease does not require restriction of activity on the basis of a particular kind of lesion. The functional ability of the heart is the important factor and should be the determinant of the amount of exercise allowed. Some patients with mitral regurgitation alone can do very little without symptoms, while others having mitral stenosis and, perhaps combined valve lesions, can carry on normal activity without difficulty. In general a patient should be allowed to do what he is able to do without inducing unusual dyspnea or fatigue. In following this routine, he is just as likely to stay well as he would be with more limitation than his condition requires, and he will certainly be happier.

In this connection the ability of a cardiac patient to tolerate pregnancy must be evaluated in much the same way. There is no specific type of cardiac lesion which contraindicates pregnancy. As in the case of other kinds of heart strain, the functional capacity of the heart is the important thing to consider. Using the functional classification of the American Heart Association, we find that patients in Grades I and II go through pregnancy very well. There is a considerably increased risk for those in Grade III, and patients in Grade IV are almost uniformly in grave danger. In our series at the University Hospital all of the cardiac deaths occurred in the Grade IV group. The mortality rate for this group was about 25%, while for the entire cardiac series it was only about 3%. With careful management the great majority of pregnant cardinals do very well, and it is a grave error to advise against childbearing entirely on the basis of an anatomical heart lesion. Careful evaluation of functional ability and attention to accessory factors such as past history, evidence of active rheumatic fever, hemoptysis, and degree of enlargement will allow us to judge more accurately what the probabilities are in relation to the risk of pregnancy.

Many patients with advanced rheumatic

valvular disease have a relatively sound myocardium, and function is not enough impaired to prevent their leading fairly normal, active lives. In others the valve lesion causes enough strain to eventually bring about failure. In those with extreme degrees of stenosis, enough mechanical barrier to blood flow is formed that serious impairment of circulation results. With surgical means of relief available for many of these patients, an important part of the care of rheumatic heart disease involves the selection of those cases which can be helped by surgery.

Commissurotomy is a mechanical aid for these patients in opening up the valve orifice to allow adequate passage of blood. It is, therefore, of greatest benefit when there is a high degree of mechanical blockage or stenosis with fairly good myocardial function. Patients with mitral stenosis may conveniently be divided into three groups as possible surgical candidates. The first group consists of patients who have had no major symptoms. Many of these will never need surgery, and it is difficult to say which ones will need it. Since it would be a purely prophylactic measure without good indication, surgery should be withheld in such patients. In the second group there are symptoms of fatigue, dyspnea, and cough associated with exercise pathognomonic of pulmonary congestion. Paroxysmal dyspnea at rest and hemoptysis are usually grave indications of the same condition. These patients are likely to show some degree of cardiac enlargement, loud pulmonary second sound, increased pulsation over the sternal area with evidence of right ventricular hypertrophy, and some degree of right heart strain in the electrocardiogram. Surgery here is definitely indicated, and can be performed after necessary medical preparation with essentially the same risk (about 5%) as in the first group. The third group consists of patients with systemic congestion which means right heart failure. Those who survive surgery have gotten good results in regard to relief, but the mortality rate is in the neighborhood of thirty per cent. For this reason every effort should be made to have sur-

gery done before this stage is reached. Patients in this group coming up for surgical consideration need careful evaluation on the basis of signs and course to judge outlook with and without operation. Patients whose failure cannot be cleared to a large extent with medical treatment and those with extreme enlargement and marked electrocardiographic impairment are particularly poor risks. Naturally the risk in any of these patients is increased during active rheumatic fever, and careful study is necessary to rule this out prior to operation. In case there has been rheumatic activity, it is well to postpone operation for several months after all signs of the active process have disappeared.

For selection of patients with aortic stenosis the same general principles may be applied. The risk is probably somewhat greater in aortic commissurotomy because access to the valve must be through the ventricular or aortic wall. However, fewer cases have been done, and the technique is likely to improve. Artificial valves for correction of regurgitation have been utilized, but these procedures are still in the experimental stage. Further work in this direction is likely to widen still more the range of help for patients with chronic rheumatic heart disease.

CORONARY DISEASE

Diagnosis of this condition has been made with increasing ease in recent years due to greater familiarity with the clinical picture and wider use of diagnostic aids, especially the electrocardiogram. Few cases of typical myocardial infarction or angina pectoris are missed, and everyone is aware of the widespread incidence of coronary disease. A few points in regard to diagnosis and evaluation of coronary disease seem in need of emphasis.

In spite of the help from accessories, a careful history is still the most important part of our study of the coronary suspect. Pain of coronary origin frequently occurs with normal physical and electrocardiographic signs, and non-cardiac pain may be present in a patient with an abnor-

mal electrocardiogram. It is easier to rely on the electrocardiogram and make a wrong diagnosis, but in order to assess the symptom accurately and give the patient a fair appraisal, it is necessary to question all aspects of the pain. Coronary pain is usually dull and centrally located with varying amounts of lateral or vertical radiation. Radiation to the jaw is common and also to the inner aspect of the arm. It is associated with exercise or other factors increasing heart work such as excitement, a heavy meal, or cold. Pains located more laterally in the chest or down the outer arm are likely to be of skeletal origin, especially if present for long periods and made worse by certain position changes or by taking a deep breath. Tenderness or soreness in the pain area usually are not associated with cardiac pain. Aching in the left chest, often more noticeable with fatigue after some effort but not during the effort, is likely to be related to nervous tension and anxiety. Of course, chest discomfort in relation to gastro-intestinal disease is well known and must be considered in the course of history taking. Although this may require considerable time, it usually allows a definite diagnosis to be made, and other parts of the examination merely supplement and complete the study.

The patient with coronary disease is likely to run an irregular course dependent upon changes occurring in the walls of individual arteries with variation in coronary flow. Greatest danger and the most varied clinical picture occur during periods of acute insufficiency of coronary circulation. It may be precipitated by thrombosis of a small branch, bulging of a plaque due to subintimal hemorrhage, unusual effort or excitement, and possibly by spasm. Coronary insufficiency may be manifested in one of three ways; 1) the abrupt onset of exertional pain of anginal type, 2) an increase in the frequency or duration of existing anginal pectoris, and 3) prolonged non-exertional pain of coronary type without characteristic signs of infarction. The danger lies in the uncertainty as to further progression of the disease with major damage to the heart. A clot in a

small branch can extend proximally to involve a major vessel, and a plaque which is causing partial occlusion may be the site of a thrombus which causes complete blockage. Because of this uncertainty I believe patients in this group require the most careful supervision, restriction of activity and food, dilator drugs to offset spasm, and anticoagulants.

My own routine in these cases calls for complete rest at first and use of nitroglycerine and narcotics for relief of pain. When comfortable the patient is allowed to sit in a chair if he desires but is allowed no walking beyond going to the bathroom, which is usually less taxing than the use of a bedpan. Oral intake is limited to liquids and small amounts of soft foods during the first few days, depending upon how he feels. Dicumarol is started at once, 200–300 mgm., initially, 200 mgm. the second day, and then every other day in doses sufficient to keep the prothrombin level at 25–30 seconds. This usually requires 100–150 mgm. every other day. Prothrombins are determined on the day dicumarol is to be given, and the doses adjusted accordingly. However, after the first three or four tests, one or two per week allows safe coverage. Prior to the use of anticoagulants, myocardial infarction of severe grade and sudden death during recurrent pain occurred in a high percentage of patients falling in the second and third groups. It is my feeling that anticoagulants prevent these complications in many cases and allow time for the formation of collateral circulation, with which the patient can survive for a long time. If the pain is very persistent or tends to recur in the beginning, it is advisable to use heparin for quicker effect on clotting until dicumarol has had time to elevate the prothrombin time. The value of so called dilator drugs is in some doubt. There is both clinical and experimental evidence that some of them do increase coronary blood flow, and I believe that their use is justified. Theocalcin and peritrate have seemed most satisfactory and are well tolerated at three or four hour intervals. This program should be maintained for two or three

weeks. If symptoms subside promptly, activity may then be resumed gradually, but medication should probably be continued for three or four weeks more. Recurrent pain or evidence of damage in the electrocardiogram calls for prolonging the convalescent period, because the danger of complications exists until the coronary circulation is stabilized. After stabilization, activity may be allowed that is in keeping with the patient's tolerance. Most patients can lead normal lives as long as they avoid strenuous exertion.

CONGESTIVE FAILURE

Certain phases of congestive failure still cause trouble from the standpoint of recognition as well as management. Even though the classical signs of failure are well known, it is easy to overlook early stages of this condition. The patient with cardiac enlargement who has some dyspnea with effort but not at rest and is able to carry on a normal level of activity for his needs probably has a diminished cardiac reserve but not congestive failure. However, his reserve may decrease gradually until he has early congestive failure with only slight changes in symptoms and signs. Suggestive symptoms are increasing fatigue and sleeplessness, often without noticeable change in breathing difficulty. In other cases subjective dyspnea and orthopnea are noticed, and it may be difficult to demonstrate any evidence of pulmonary congestion because râles are only present when recumbent position or exertion has been prolonged. In such patients elevation of heart rate and blood pressure above the individual's usual level are suggestive signs. Gallop rhythm, cervical venous pulsation in the erect position, and increase in heart size by x-ray measurement give valuable confirmation when present. It is important to recognize these early stages of congestive failure because it may be present for a long time at this level before more obvious signs develop.

Acute left ventricular failure may not be recognized as a serious situation by either patient or

physician because of its peculiar behavior. Some patients have repeated episodes of nocturnal dyspnea but feel fine with average exercise during the day. The physician is confused by the history of shortness of breath and palpitation, which could be of functional origin, since examination later fails to show any signs of congestion. It is surprising how quickly congestive signs can disappear as the attack subsides. The description of dyspnea and suffocation coming on in the recumbent position and relieved by staying upright, especially if cough is associated, is enough for presumptive diagnosis of acute left failure in patients with cardiac enlargement. It usually affects those with hypertensive, coronary, or aortic valve disease. However, the same symptom pattern occurs in mitral stenosis on a mechanical basis and without actual myocardial failure. Nocturnal dyspnea is a serious symptom. In the course of a few episodes the patient may progress into frank pulmonary edema which can be rapidly fatal, and yet most patients can be maintained on treatment for long periods.

Principles of treatment in these types of congestive failure do not differ from those for failure in general. Rest is required during the period of symptoms and until the circulation has been stabilized. In any degree of congestive failure digitalization is indicated as soon as the condition is recognized and for as long as the patient is likely to need it. When failure results purely from prolonged strain of chronic heart disease, permanent maintenance of digitalis will almost certainly be necessary. Even though symptoms are intermittent, as in paroxysmal nocturnal dyspnea, digitalis must be continued to avoid serious consequences. Some patients have failure only with the increased strain of a complicating factor such as active rheumatic fever, coronary insufficiency, or pulmonary embolism. In these instances there is a good chance that digitalis will not be required after the period of extra strain has passed. However, it is important to remember that the case of congestive failure with complicating factors does not always show the expected response to therapy.

It is dangerous to give more than an average dose of digitalis because the pulse does not slow and the congestion does not clear promptly. Digitalization should be carried out in the usual way according to the patient's tolerance in the first day or two and then maintained at an even level. There seems to be a great tendency to use 0.1 mgm. of digitoxin as a sustaining daily dose, but I am sure that the adult requirement is closer to 0.2 mgm. daily, perhaps averaging 1.2 mgm. per week. The patient's tolerance for the drug should not be exceeded no matter how resistant the failure, but greater use can be made of diuretics, oxygen, and general supportive measures, as well as more direct treatment of the complication itself. Diuretics have greatly improved, even some of the oral ones now being highly effective. They probably should be used more. They are just as effective in pulmonary edema as in peripheral edema, and in the presence of congestion should be continued past the point of initial symptom relief and kept up until all congestive signs have cleared and stable body weight indicates that there is no longer excess tissue fluid. When this stage is reached, the heart has a much better chance of regaining some degree of reserve, and with proper maintenance therapy, the patient may be able to return to some degree of activity with reasonable comfort.

SUMMARY

An effort has been made to point out some of the changes in attitude toward cardiac practice brought about by advances in our knowledge in recent years. We now have the means to make specific diagnoses, to assess the degree of functional impairment in a given case, and to recognize relatively slight but important changes in the patient's course which call for variations in treatment. Progress in both medical and surgical methods has greatly increased our ability to control the effects of heart diseases and justifies an increasingly optimistic attitude toward the cardiovascular problem.

*14 East Eager Street
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SYMPOSIUM ON THE MEDICAL AND LEGAL ASPECTS OF MALPRACTICE*

INTRODUCTION

LANSDALE G. SASSCER, Esq., *Moderator*

Mr. Stanley, Gentlemen of the Panel, Guests here this evening:

It is an honor, a privilege and a pleasure to me to act as Moderator at this gathering.

We are fortunate in having on the panel gentlemen from the Bar Associations and the Medical Profession who through training and experience are familiar with the subject of this Symposium this evening.

I will, therefore, not invade their field, and I will confine my part of the program to the duties of the Moderator, which I understand are to keep the program moving, expedite things, and maintain an orderly proceeding.

Most of you no doubt are familiar with the work and objectives of the Medicolegal Committee, but for the information of those of you who are not, the underlying thought back of the formation of this Committee was to create a group made up of the members of both professions, for the purpose of synchronizing and coordinating interlocking problems. And this work has been helpful not only to these two great professions, but it has been in the public interest.

When Mr. Macmillan, one of the members of the Panel tonight, was President of the Baltimore Bar Association he appointed my fellow countian, Mr. John Stanley, as Chairman of the Medicolegal Committee of the Baltimore Bar Association.

Shortly thereafter, Mr. Stanley was called to higher honors, as President of the Maryland State Bar Association.

After he became President, the scope and the membership of the Committee was extended by the appointment of the present Medicolegal

Committee, which is made up of an equal number of representatives from the Bar Association and the Medical Profession.

The Committee is broken down into sub-committees:

The Committee on Court Procedures, which embraces medical testimony, the attendance of doctors in Court, and similar matters of interest and to the convenience of the members of both professions.

There is a sub-committee on Inter-Professional Relations, to which is assigned problems resulting from misunderstandings between the members of the legal and medical professions.

There is also a committee on Symposia Management, under whose sponsorship this meeting is being held tonight. That is a third of those sub-committees.

The purpose of this sub-committee is to conduct symposia on matters of common interest to both professions. The topic of the inquiry this evening is The Medical and Legal Aspects of Malpractice.

This is of growing interest, on account of the great number of malpractice suits that are being filed.

We are fortunate in having on the Panel leaders in both professions. The lawyers will outline the legal phases of malpractice litigation, and the doctors will outline some practical aspects that can be helpful in discouraging unwarranted litigation and in defending unfounded suits.

Each member of the Panel will make an oral presentation, following which there will be a question period.

I understand from the Committee that past experience has shown that the most satisfactory and expeditious procedure is to have the questions from the audience reduced to writing, and

* Presented before the members of the Medical and Chirurgical Faculty on Thursday, February 4, 1954, at the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore 1, Maryland.

then directed by the Moderator over the microphone. In this way, the questions will be audible to the audience as well as to the Panel.

Pads and pencils will be, if they have not already been, distributed to the audience. And upon the pads you may write questions which you desire directed to the Panel.

Following an oral statement or presentation by the members of the Panel, the meeting will then be conducted as a question period.

The first member of the Panel whom we will have the honor of hearing tonight is a gentleman who was formerly President of the Baltimore City Bar Association, who is an active trial lawyer, a member of the firm of Semmes, Bowen & Semmes, and an outstanding member of the Maryland Bar. He is a graduate of the University of Maryland.

It is now my pleasure to present to you Mr. William D. Macmillan.

EXCERPTS FROM OPINIONS IN MALPRACTICE CASES DECIDED BY THE COURT OF APPEALS OF MARYLAND

WILLIAM D. MACMILLAN, Esq.

Thank you, Mr. Moderator, for those kind words.

I might say, ladies and gentlemen, and honored guests, and fellow panel members, that the Moderator is well named here, and we will call him Moderator instead of Judge or Toastmaster, because he is the one that gets those questions that you are going to send up, and then he moderates them. And he moderates them to the point that we will be able to answer them. We will have them all screened. And I will say that there are some of you who may ask questions, and certain answers will be given, but you may not recognize them as being answers to your questions!

Now, I was told that I should read my paper. Well, I have written this paper, and I will read it, so that I will not ad lib, because I am limited to fifteen minutes on the subject that has been given to me to present this evening's Symposium on "The Medical and Legal Aspects of Malpractice."

This paper will be confined to the purely legal aspects of malpractice and, primarily because of the shortness of available time, it will be limited to excerpts from opinions in malpractice cases decided by the Court of Appeals of Maryland. After all, for our purposes, we are only concerned

with what the law is in Maryland on this subject.

It is of interest to note that a total of eleven malpractice cases, three of which involved dentists, have been reviewed by our Court of Appeals.

The first case—State Use of Janney against Housekeeper, in 70 Maryland 162, was decided in 1889, it being an appeal from the Circuit Court for Harford County, and the latest or last case to be reviewed, that of State Use of Kalives vs. Baltimore Eye, Ear and Throat, and so forth, 177 Maryland 517, was decided in 1940.

Of the eight cases against physicians and/or surgeons, three resulted in directed verdicts by the trial court in favor of the defendant doctors, all of which were affirmed on appeal.

In two cases the jury found in favor of the defendant doctors, and those cases were affirmed on appeal. And in three cases the jury found for the plaintiff-patient a money verdict, all of which were reversed for a new trial.

Of course, I might as well make it known at the outset that, more often than not, I have been counsel for the defendant when there is a malpractice suit brought. I have had that pleasure! But I know that somebody is going to

ask that question, so I might as well let you know in advance how I stand on the situation.

Of the three cases against dentists—and the reason I include dentists is because, as you may know, dentists are included in the same category as physicians and surgeons, and the same rule applies to them as it does to physicians and surgeons.

Of the three cases against dentists, each was sent to the jury by the trial court and the plaintiff-patient in each case recovered a money verdict, but on appeal one was affirmed and two were reversed without a new trial.

Hence it will have been noted that out of the entire eleven cases of malpractice, only one money verdict for the plaintiff-patient was allowed to stand on appeal, and this was against a dentist.

1. Definition of malpractice

Now, as to the definition of malpractice. What does it mean?

Malpractice may be defined as the failure upon the part of a physician, surgeon or dentist properly to perform the duty imposed upon him by law arising out of his professional relation to his patient whereby the patient is injured. Failure to so act constitutes negligence.

The duty thus imposed by law is to be found in the decisions of the Court of Appeals of Maryland as distinguished from statutory law enacted by the State Legislature. There is no statutory law in Maryland governing the duty required of a physician, surgeon or dentist to a patient.

2. The nature and extent of the duty that is required

In the very first malpractice case reviewed by the Court of Appeals, as I said before, in 1889, the Court set forth the legal duty and the degree of care required, which ruling was adopted with approval and quoted verbatim in the latest or last case, decided in 1940, as follows:

“It was the duty of the professional men to

exercise ordinary care and skill, and this being a duty imposed by law, it will be presumed that the operation was carefully and skillfully performed in the absence of proof to the contrary. As all persons are presumed to have duly performed any duty imposed on them, negligence cannot be presumed, but must be affirmatively proved.

“This principle is especially applicable in suits against physicians and surgeons for injuries sustained by reason of alleged unskillful and careless treatment. The burden of proof is on the plaintiff to show a want of proper knowledge and skill.”

It is, therefore, indeed significant to find that the Court in 1940 approved in toto the ruling of its predecessor in 1889, an elapsed period of fifty-one years. It can be safely said that the trial courts today follow the principle of law quoted above as being the settled law in Maryland.

The Court decisions intervening the first and latest case have in other respects made important pronouncements relating to suits for malpractice against physicians, surgeons and dentists.

3. The degree of care is not the highest or greatest, but only ordinary care

In the second case decided, Dashiell against Griffith, 84 Maryland 363, in 1896, it was held by our Court of Appeals:

“This Court has seldom, be it said to the credit of the profession”—of course, there was only one case before that—“been required to pass upon questions of medical malpractice, but the law is settled in numerous well considered cases elsewhere, that a physician or surgeon who holds himself out to the world to practice his profession, by so doing impliedly contracts with those who employ him that he possesses a reasonable degree of care, skill and learning, and he is therefore bound to exercise and is liable for the want of reasonable care, skill and diligence, and he is responsible in damages arising as well from want of skill as from neglect in the applica-

tion of skill. The cases are generally agreed upon the proposition, that the amount of care, skill and diligence required is not the highest or greatest, but only such as is ordinarily exercised by others in the profession generally."

Now, you will have noted that the amount or degree of care, skill and diligence required being that which is ordinarily exercised by others in the profession generally, means that degree of ordinary care which is exercised by other such doctors in the same locality and in the same line and school of practice as the defendant there. In other words, a country doctor-defendant is held to the same standard of practice followed by other country-doctors in his locality, and a general practitioner in the City is held to the standard of other general practitioners in the City, and a specialist in any given field must conform to the practice and procedure followed by other similar specialists in his locality.

4. *Ordinarily the mere occurrence of injury or unfavorable result is neither actual nor presumptive evidence of negligence*

In *Streett against Hodgson*, 139 Maryland 137, in 1921, the Court of Appeals reviewed a case where the plaintiff-patient sustained an X-ray burn. The Court submitted the case to the jury to determine whether it was negligence to use a static machine, as defendant used it without a meter and without protecting the leg; and whether the burn, assuming there was a burn, was due to the failure to use a meter and protection for the leg.

The Court held, at page 148:

"It remains to consider whether the jury was properly instructed,"—that is, by the Court—"that it could not infer negligence from the fact of the burn alone; or whether the maxim *res ipsa loquitur* applies to such an occurrence."

The term *res ipsa loquitur*, as you Latin scholars of the medical profession know, is not a prescription for aspirin, but it means that the thing speaks for itself.

Quoting from the Court's opinion, it was held:

"The precise question has not been decided by this Court, and in the few cases elsewhere in which it appears to have been decided, the decisions are not harmonious.

"The reasoning of the Courts which hold that the maxim does not apply in such cases seems more in consonance with the principles governing the relations generally between physicians and patients as announced by this Court in numerous cases. At any rate, in the absence of evidence from which, without speculating, the jury could draw a reasonable inference from the mere happening of such an accident, it should not be permitted to infer negligence from the occurrence alone."

And later, *Fink vs. Steele*, 166 Maryland 354, in 1933, the Court had occasion to say:

"No physician or dentist is chargeable with the results of his efforts if he has applied the degree of care and skill ordinarily required and to be expected of one of his profession in the treatment of disease or injury."

However, there are certain instances where the occurrence of an event inherently implies negligence.

In the case on appeal of *Dr. Hunner against Stevenson*, 122 Maryland 40, in 1930, the issue of fact involved was whether a cigarette drain was left in the patient's body during the operation or later during the after-treatment. And the question was whether that was evidence of negligence on the part of the defendant-doctor.

The Court held, at page 60:

"Indeed, the attorneys for the appellant say"—and that is the appellant *Dr. Hunner*—"in their brief: 'We entirely agree that, if in the case at bar *Dr. Hunner* had lost a sponge in the female plaintiff's body at the time of the operation, whether placed by him or by another in his presence, he should be held responsible;' and we are of the opinion that such admission can well be made, for we would not be willing to announce a contrary rule."

Now, then, the next point that is developed by an examination of these Maryland cases—

and that is all I am giving you—is what you find from those Maryland cases, so that you will understand what the Maryland law is with respect to the extent of the duty and the obligation of a physician or surgeon to his patient, is:

5. *The presumption is that the physician or surgeon used due care and the burden rests upon the plaintiff to prove to the contrary*

In the first case of malpractice, *supra*, and also in the case of Angulo against Hallar, in 137 Maryland 227, the Court said:

“But while it is the duty of the professional man to exercise ordinary care and skill, a duty imposed upon him by law, it will be presumed, in the absence of proof to the contrary, that the operation or work done by him was carefully and skillfully done. And because of such presumption, want of skill, or negligence, cannot be presumed, but must be affirmatively proven.”

6. *Plaintiff has the burden of not only proving negligence but also to prove that the injury complained of resulted directly from such negligence*

In other words, the negligence must be the proximate cause of the injury complained of.

In Angulo against Hallar, *supra*, the Court held:

“Involved in the burden placed upon the plaintiff, was the necessity of showing that the professional acts of the defendant, which are alleged to have produced the injury complained of, did in fact cause such injury. In this case, there is little or no evidence showing that fact.”

In the latest case decided by our Court of Appeals in 1940, *supra*, involving strictly speaking, malpractice—and when I say the latest case, I am not referring to any cases that have been brought against hospitals as such, because there are later cases than this against the hospitals—the Court said:

“To constitute actionable negligence, there must be not only causal connection between the negligence complained of and the injury suffered, but the connection must be by a natural

and unbroken sequence, without intervening efficient causes, so that but for the negligence of the defendants, the injury would not have occurred. It must not only be a cause, but it must be the proximate cause.”

And quoting again:

“In our opinion, there must be something more than a showing that the evidence might be consistent with the plaintiff’s theory of the cause of death. It must be such as to make that theory reasonably probable, not merely possible, and more probable than any other hypothesis based on such evidence. In brief, the evidence must justify an inference that the death in the instant case resulted from the negligence of the defendants, or at least some one or more of them, rather than from some other cause.”

7. *Consent of patient*

Now, the next point which comes about by this review of the Maryland cases is the matter dealing with the consent to be obtained by the physician or surgeon from the patient.

In the very first case again, the case that was decided in 1899, a husband sued for his wife’s death following the removal of her right breast. It was supposed at first she had a tumor but later it was ascertained to be a cancer. Her husband asserted that he was willing to permit the operation for tumor, but he specifically objected to the doctors operating if it was a cancer.

The Court held:

“Surely the law does not authorize the husband to say to his wife, you shall die of the cancer, you cannot be cured, and a surgical operation affording only temporary relief, will result in useless expense. The husband had no power to withhold from his wife the medical assistance which her case might require.”

“If the plaintiff alleges that there was no consent, he must establish his affirmation by proof. The party who allows a surgical operation to be performed is presumed to have employed the surgeon for that particular purpose.”

Since this paper is limited to the points of

law decided by the Maryland decisions, there will be no attempt made to discuss other phases involving consent generally. For instance, the advisability of obtaining written consent from adults, as well as from parents of minor children and others.

8. Termination of treatment

Now, with respect to the termination of treatment, the Court has held as follows:

"We fully agree with the plaintiff's contention, that when a physician is employed to attend upon a sick person, his employment as well as the relation of physician and patient continues, in the absence of a stipulation to the contrary, as long as attention is required, and the physician or surgeon must exercise reasonable care in determining when the attendance may be properly and safely discontinued. Whilst these cases seem to refer to the attention rendered by a physician or surgeon at the home of the patient, or where the physician or surgeon is compelled to leave his office to bestow such attention, yet, however, the principles of law controlling the right of recovery under such circumstances are practically the same. If an office patient fails to come to the office of the physician or surgeon whom he employed and from whom he has received careful and skillful treatment, and then fails to return to the office for further treatment, and in consequence thereof suffers injury, he is not entitled to maintain an action against the physician, because it is his own default and misfeasance."

9. Generally the interns, nurses and orderlies employed by a hospital are the servants of the hospital and not of the physician or surgeon treating the patient therein.

In Hunner vs. Stevenson, supra, it was held:

"It would be unreasonable to expect such a one as the record shows the appellant to be—performing operations in five different hospitals in Baltimore, and in one at Frederick, in addition to his other practice—to continue to dress

the wounds and have personal charge of the after-treatment in all cases until the patient is discharged from the hospital."

And then further:

"Having reached the conclusion that the appellant"—that is Dr. Hunner—"cannot be held responsible for the negligence, if any, of the hospital physicians, nurses or interns in the dressings of the wound after the operation was performed, if he did not know of or was not privy to such negligence, and it was not discoverable by him in the exercise of ordinary care, we will now as briefly as we can consider the various rulings of the lower court."

After our Court of Appeals rendered that decision in Hunner vs. Stevenson, other courts throughout this country followed it, and the weight of the authority today is in line with what our Court held back there in 1930 in that case.

10. Weight and sufficiency of the plaintiff's evidence in a malpractice case

In Fink vs. Steele, supra, in 1934, the Court held:

"In actions for malpractice against physicians and surgeons, 'the main issue of the defendant's use of suitable professional skill is generally a topic calling for expert testimony only*** and for lack of it the Court may rule, in its general power to pass upon the sufficiency of evidence that there is not sufficient evidence to go to the jury.' There may be cases in which there is such gross negligence and unskillfulness as to dispense with professional witnesses, but this is not one of them. The rules of law in the cases of physicians and surgeons have been held by this Court to be equally applicable to dentists."

Now, that is an important decision, which gives rise to lawyers, who represent plaintiffs, saying, "I cannot go to Court, because I cannot get a doctor to testify against another doctor."

I know that such an attitude exists and there ought to be, I think, some arrangement made to straighten that out, because I really believe from the experience that I have had over a period of thirty some years in handling these kinds of

cases, along with Mr. Tschudi and the late Mr. Jim Dennis, in the past, and now with Mr. Andy Anderson over there, who is counsel for the Medical and Chirurgical Society of Maryland, and also my friend here, Bob Bartlett, who comes into the picture about as much as I do, I feel that by a proper arrangement between the two professions a lawyer who represents a plaintiff can be made to understand that the defendant doctor is not guilty of malpractice if he is indeed not guilty of it.

As a matter of fact it has been my observation that only a very small number of malpractice suits have involved legally sufficient facts to establish negligence on the part of the doctor. The great majority of cases are predicated solely upon the patient's claim that he or she did not obtain a satisfactory result. It will have been noted that of the eight cases reviewed by our Court of Appeals against physicians and/or surgeons, five resulted in verdicts for the defendant-doctor, and the remaining three in favor of the plaintiff-patient were reversed for new trial. In other words there is no case in our appellate court where a verdict for the plaintiff-patient was affirmed.

If doctors are to be subjected to malpractice suits merely because the patient has not obtained a satisfactory result, then, by the same token, a lawyer is exposed to the same type of claim. It must be remembered that in every law suit one side wins and the other side loses whereas not every doctor's patient dies or fails to completely recover. The loser in a law suit obtains a bad result, but that by no means indicates his lawyer was guilty of malpractice and the same is likewise true as to the Doctor whose patient dies or does not completely recover.

I am confident no lawyer enjoys filing suit against a doctor for malpractice and I believe that if a complaining patient's lawyer, at the outset, could obtain the opinion of a reputable physician or surgeon on the facts, then in most cases he could be convinced where no justifiable cause of action exists and hence no such suit would be filed or tried. Therefore I suggest that

some arrangement be made by the currently established joint medico-legal committee to accomplish that end.

Now, when we sit down and confer in that room out there, Andy Anderson and the rest of them, we try to find out from the experts whether or not the doctor being sued is indeed guilty of any negligence or malpractice.

Why do you suppose we would be taking our time to come up here if we were not desirous and anxious indeed to be told, and to find out for ourselves, whether or not there was anything done that could be considered as being contrary to the ordinary practice and procedure followed by a doctor in a similar situation.

So it may be we will eventually come around with an arrangement whereby plaintiffs' lawyers will not have occasion to complain about not being able to discuss their case with competent and impartial doctors.

11. The Statute of Limitations

When does the cause of action accrue? Well, the Court of Appeals in *Hahn vs. Claybrook*, 130 Maryland 179, in 1917, held that the three years statute applied to malpractice cases generally, but eighteen months if death results.

In that case above referred to, the Court said:

"The ground of the cause of action in this case was the discoloration of the plaintiff's skin by the use of the drug referred to in the evidence,"—and the reason I said "the drug referred to in the evidence" is because I cannot pronounce this name very well, the name that they have got here. "And the statute began to run from the time of the discovery of the alleged injury therefrom. As stated by the Court below, when she began to be discolored that showed an injury and that was the injury of which she had a right to complain."

So obviously, when the injury has manifested itself, that is when the statute begins to run.

Now, in conclusion, I have just set forth the principles of law dealing with the purely legal matters of malpractice, as announced by the Court of Appeals. And regardless of what may

be the attitude of courts elsewhere, I respectfully submit that our Court of Appeals of Maryland has not promulgated harsh or unreasonable standards of conduct for the medical profession.

And if time permitted, I should like to discuss certain specific aspects of a typical malpractice case, but my allotted time is up, and I must sit down.

*Ten Light Street
Baltimore 2, Maryland*

MR. SASSCER: Thank you, Mr. Macmillan. Your remarks were certainly embrative, instructive and interesting.

The next presentation will be from the Medical Profession, by an eminent physician who graduated from the University of Maryland Medical School in 1929. He trained at the University of Maryland Hospital and the New York Orthopedic Hospital until 1936. He has been in practice here since 1936, with the exception of a period of active duty in the Army Medical Corps from 1942 to 1945. He is certified by the American Board of Orthopedic Surgery. He is an Associate Professor of Orthopedic Surgery at the University of Maryland School of Medicine.

It is now my honor to present Dr. Henry F. Ullrich.

MALPRACTICE SUITS MAY BE AVOIDED

HENRY F. ULLRICH, M.D.

Mr. Moderator, Members of the Panel, Ladies and Gentlemen:

I would like to discuss with you the surgical and medical aspects of malpractice, with a few suggestions. I will try to develop the idea that malpractice suits may be avoided.

A patient who presents himself to a physician or is referred by another physician begins an implied contract that the doctor will assume his obligation to the patient and that the patient will assume his obligation to his doctor. This confidence is implied since no one is usually forced to go to a certain doctor and no doctor is usually forced to take on this or that patient for diagnosis, treatment, and rehabilitation. Such a doctor-patient relationship exists and is on a real or implied basis until one of several things occurs:

1. The patient may get well and be discharged.
2. He may require either no treatment or no further treatment.
3. Or the patient may seek other medical advice.

The physician himself may not abandon the patient unless the patient is specifically told to seek other medical advice.

To be sued for malpractice—or even be accused of malpractice—must indeed be a most distressing experience for anyone. No one is immune to a malpractice suit. It is said that not only are duly licensed and qualified physicians and surgeons thus jeopardized, but also chiropractors, naturopaths and even veterinarians have been thus assailed. The mere accusation of malpractice will do much harm to a physician's reputation, and create considerable ill-will on the part of the public to the rank and file of honest physicians and surgeons. At times, exercise of the highest skill and judgment with most meticulous attention will not always ward off an unjust claim. The mere filing of such a suit does harm to the physician's reputation. This accusation usually results in a press notice—but his vindication does not always merit the same degree of publicity.

The practice of orthopaedic surgery probably brings one into more contact with the legal profession and law than does any other one branch of surgery. The orthopaedic surgeon is often called upon to evaluate disability in an individual whom one of his colleagues has treated. He is called upon to give prognosis in many instances,

as well as to operate upon individuals ranging in age from infancy to adulthood for acute and chronic conditions. Many of his patients fall in to the so-called elective category, where an operation may not be life-saving. It is done to add to the cosmetic appearance of the individual, and additional risk and responsibility are, therefore, often involved. If the law did not give latitude to the exercise of ordinary diligence and judgment by a prudent individual acting under similar circumstances in a given locality, possibly many would shy away from accepting these responsibilities that are too often placed upon practicing physician and surgeon.

The doctor-patient relationship is twofold: The patient has certain definite responsibilities to his physician, and, secondly, the physician has certain definite responsibilities to his patient. The patient's responsibility to his physician is to carry out such orders as are given him as far as possible. He should try to understand, the diagnosis, if this be given, and the prognosis, and what can reasonably be expected of the treatment that has been outlined by his physician. He must give his consent for such treatment or for surgery. If the patient is a minor, consent must be obtained from the parents or guardian. If he is an adult without all of his faculties, consent should be obtained from a responsible member of his family. Further, the patient should report immediately to his physician any untoward reactions or symptoms which may follow the treatment that has been given.

The responsibilities of the physician to his patient are even greater. He must duly exercise the ordinary care and ordinary skill of a similar physician in performing his duties to that particular patient. He should arrive at a diagnosis, if possible, by what means are at hand, and employ such additional means as he deems necessary to arrive at a correct diagnosis for the care and possible cure of the particular condition.

When a diagnosis is established, he should communicate this information either to the

patient, if it is expedient, or to a member of the family, if the patient be a minor or if the diagnosis be of such a nature that it would be unwise for the patient to know his condition. The question of communicating a diagnoses such as incurable carcinoma, as well as other hopeless lesions, is a matter of judgment. The medical profession is now divided on that particular point. When an operation is indicated, the patient should be informed as to what he has, what is contemplated, and the probable risk that is involved, as well as the probable length of time that he will be required to spend in the hospital—and this, of course, would be true, barring unforeseen complications. He should not promise a cure. No one can promise that a particular form of treatment will cure a particular form of illness in a particular patient. No one can guarantee a cure. One can only guarantee to do the very best that is humanly possible for him to do, and no more. An honest physician or surgeon can no more guarantee a cure than an attorney can guarantee an acquittal or a conviction in a given case. A physician should report his findings of operation either to the patient or to a member of the family, why it was done and what the course of the illness or future treatment will probably be. He should keep accurate records of his patients, the dates of their visits, his impressions, his opinions, his diagnosis and prognosis, as well as many other points of information with regard to the patient. He should supervise, as far as possible, the activities of employees and assistants.

However, to do this, if it were carried to unreasonable lengths, would mean that a physician would have to treat one patient personally to the exclusion of other patients.

The physician should limit his work to a field within the scope of ordinary skill and training, to practice that particular branch of medicine or surgery in the locality in which he is working. And consultations should be requested in cases where things are not proceeding satisfactorily or where additional help is necessary. The mere question of consultation does not relieve a phy-

sician of primary responsibility, but it does create an atmosphere of good will between the doctor and the patient that probably could not be had by other means.

How can malpractice suits be minimized or avoided?

First, by the physician carrying out the above suggestions to the patient to such an extent that the execution of them is practically automatic.

The physician should be careful in making any statement which could be construed as an admission of fault on his part, even though it were not so intended. Not only should he exercise ordinary skill and due care in treating his patients, but he should exercise extraordinary tact not only in handling his patients but also members of their families. Any sensing of an undercurrent of dissatisfaction or discontent should automatically suggest consultation.

He should advise his patients of any intended absences, and recommend a qualified substitute.

He should select such patients, especially for surgery, as are within the limits of his field of experience and knowledge, and not attempt surgery that is beyond the scope of his training and ability to perform with a reasonable outlook for success.

Violation of confidence on the part of the physician, except to duly authorized sources or with the patient's permission is, in my opinion, self-evident.

In cases of fracture or suspected fracture, X-ray examination is imperative, and this examination should be made whether the patient is able to pay or not. The mere question of inability to pay does not relieve the physician of these responsibilities from a moral if not from a legal point of view.

Last, and in my opinion one of the most important causes of malpractice accusations, is careless and unwarranted criticism of another physician's work. It is easy enough to say,

"who did this, why did he do it," and, "did a physician or surgeon do this or that." The second physician who was called upon in the case or who was called upon to evaluate another's work probably knows most of the circumstances, but, in many cases, does not know all of the circumstances which may have led to a result which may be less than what was expected. Perhaps the patient did not tell the entire truth in outlining his history. A careless slip of the tongue, a raised eyebrow, or even a quizzical nod of the head may, at times, be enough to initiate a feeling of distrust on the part of the patient towards his original physician.

Medical malpractice suits can be materially lessened, if not completely avoided, by exercise of scrupulous attention to the requirements of good medical practice and exercise of extraordinary tact with ordinary skill and care for the reputation of his colleagues.

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MR. SASSCER: Thank you, Dr. Ullrich. Your remarks were enlightening and stimulating and inspire even greater confidence in your profession.

The next member of the panel received his A.B. and M.D. degrees from Johns Hopkins University. After graduating he spent six years on the surgical house staff at Johns Hopkins, and eleven years in full time on the staff at the Johns Hopkins Medical School. He has been secretary of the American Surgical Association and Chairman of the American Board of Surgery. He has been in an active and successful practice since 1938, and is now visiting surgeon at the Johns Hopkins Hospital, the Union Memorial Hospital, and Chief of Staff at the Maryland General Hospital.

It is now my privilege to present Dr. Warfield M. Firor.

SURGEON'S CONCEPT OF MALPRACTICE

WARFIELD M. FIROR, M.D.

Mr. Sasscer, Members of the Panel, Ladies and Gentlemen:

I have been asked to talk for a few minutes on the surgeon's concept of malpractice, and I will not proceed very far before it will become obvious to all of you that such a concept is totally different than the exact, precise, and apt definition handed down by the Court of Appeals.

In the broadest sense, the thesis that I shall try to develop is that malpractice is bad practice.

In order to contrast the difference between a doctor's concept of malpractice and the legal concept, I might briefly point out that acts or omissions, either actual or alleged, by a doctor which form the basis of legal action fall into one of three categories: either a crime, or a breach of contract, or a tort. And for the benefit of my medical conferees, I would like to point out that I found out the other day that a tort is an injury or harm inflicted, either with or without force, to a person or his property. Unfortunately, the term malpractice connotes this type of thing. But actually, in its broadest sense, malpractice is bad practice. And from the point of view of the doctor, it can be sub-divided into three groups:

First, professional incompetency;

Second, deliberate disregard of the patient's welfare; and

Third, gross carelessness.

Let us examine these for a minute.

Did it ever occur to you that the reason for the paucity of malpractice suits in Maryland is due primarily to the high degree of professional competency and the quality of medical care given to people in this state? In contrast, think of the states or communities in which malpractice suits abound. In every instance, it is a locality in which all sorts of medical cults flourish: chiropractors, naturopaths, hydrotherapists, electrotherapists are in abundance, and consequently orthodox medical practice is reduced

to a certain degree by the cultists' standards of performance.

The surest way to diminish malpractice suits is to maintain the highest possible level of professional competence among doctors. And this is primarily a function of the Medical and Chirurgical Faculty and its associate groups. It is the doctor who does not avail himself of the opportunities and facilities of the sectional meetings of this Faculty, who does not keep abreast of the time, who is guilty of malpractice. There should be some way whereby the practicing physician's competence could be checked from time to time. It has even been suggested that re-examinations be held periodically. This is not the time nor the place to argue that point, but suffice it to say that it is a primary responsibility of the medical profession to weed out its incompetent members. I would call to your attention the fact that there are two agencies available: There is a Medical Board of Examiners, who by law are authorized to revoke the license of a practitioner, and there is the Committee on Professional Conduct. Unfortunately, this Committee seldom gets any complaints, except an occasional one of unfair charges on the part of the doctor. Actually, it is the ideal place where members of the medical profession could point out gross incompetence on the part of their conferees.

The second aspect of malpractice, as I view it, is deliberate disregard of the patient's welfare. Ordinarily this is the result of some medical enthusiast who is far more interested in the development of his particular remedy or his operation than in the welfare of the patients. Just today my attention was drawn to a case in point: Following delivery, a woman was terribly concerned with the fear that the baby was not perfectly formed and had to go back to the hospital. She was concerned about her husband's economic insecurity. And throughout this period

of anxiety, she lost nine pounds in weight. She was referred to a specialist, who on hearing of her anxiety and fear, and her loss of nine pounds in weight, immediately diagnosed an inward goiter, told her she needed an operation, proceeded to operate on her, and removed virtually the entire thyroid gland, without doing the well known and ordinary tests. Needless to say, he was a goiter specialist. And fortunately for him, this gentleman lives and practises in another state. So that is off the record. But it illustrates my point.

Every doctor in this room I am certain could quote one or two instances where a medical enthusiast had been so eager to build up his series of cases, or develop his particular form of therapy, that he had no primary regard for the welfare of the patient. I once knew a doctor who developed a treatment for ulceration of the colon, and in his enthusiasm performed this operation, but without doing any primary tests, he removed a perfectly normal colon. That patient died as a result of that operation, five days later and the autopsy showed the patient had a carcinoma of the pancreas, and a normal colon. In my book, that is malpractice of the worst sort, but it is not the sort that comes to the attention of either the family or the legal profession.

In the third place, malpractice can be gross carelessness.

The shortcomings of the surgeon are well known to all of you, and we will pass them over and direct our attention for a minute or two to the fact that the general practitioner or internist is rarely if ever the object of a malpractice suit. And I think this is because the work they do is not subject to close scrutiny, or is not an acute process on which people's attention is focused. But I would like to point out to the general practitioners here that there are two or three aspects of negligence which they should be aware of: First, if you agree to make a call on a patient, a new patient, and fail to do so, you are guilty of breach of contract.

Secondly, if you agree to accept a patient,

regardless of whether the patient is a charity patient or an individual who can reimburse you, it is your obligation to use in the diagnosis as well as the treatment, ordinary skill, knowledge and care. I think that most doctors who are general practitioners, focus their attention on the therapy and neglect diagnosis. Strictly speaking, negligence in diagnosis is far greater malpractice than misdirected therapy.

Finally, for the general practitioner and for all of us, there is the duty of disclosure. If the doctor pursues a certain form of therapy for a while and fails to get results, or if he comes to the end of his tether and is not clear as to the diagnosis of the patient's illness, he is obligated to tell the patient or the relatives that such a state exists, and to give them the choice of getting another doctor or to call in a consultant. Now, obviously this subject of the duty of disclosure has many ramifications, one of which has been touched on by Dr. Ullrich—what is a doctor's obligation to tell the patient if he has an inoperable malignancy? Well, the answer to that question is that there are so many individual variants that this is a matter of judgment and not precision, and the answer cannot be accurately stated.

I think one might summarize the point of view that I would like to develop, namely, that malpractice is really bad practice, by looking for a minute at a doctor's attitude toward his profession. A doctor in the first place may look upon the practice of medicine and surgery as a business, that every patient is a customer, and he will advertise his wares, his services, as far as he can possibly do so ethically. He will sell his patient to another doctor if he gets a cut on the fee. Now, I know you lawyers have a totally different philosophy on fee splitting, but how would you like to be a patient in need of an operation and have a physician who would send you to a perfectly horrible surgeon, who was not capable of doing that operation, because your physician is going to get half the fee? You see, what your fee splitting really boils down

to is selling your patient to the surgeon who will give you the biggest cut, regardless of his ability. So that is one attitude that physicians and surgeons can have, that this is a business, that every patient is a customer, and I will sell him to the highest bidder.

A second attitude is one of pure science. Medicine is not yet an exact science, and it will not be for a long time, but the advances made in the last fifteen or twenty years are so tremendous that it is a great temptation to a man with a love of experimentation to view the practice of medicine primarily as pure science; then every patient is a subject for either experimentation or the acquisition of new knowledge.

The third attitude is that the practice of medicine is an art, that it is the ministry of healing, and that the patient-doctor relationship is essentially that of the ministration of healing.

Well, now, common sense tells you that there must be some of all three of these ingredients in a doctor's attitude toward his profession.

But I submit to you that if every doctor in the State of Maryland felt primarily that his relationship to the patient was that of a practitioner of an art, and that if he had a reasonable

scientific alertness, and was fair in his charges, there would be very little malpractice.

*1101 North Calvert Street
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MR. SASSCER: Thank you, Dr. Firor. I think all of us after having heard you and Dr. Ullrich can easily understand how both of you quickly gravitated to the top in your profession.

The last of the oral presentations will be made from the legal division of the panel, by a gentleman who, like Bill Macmillan, has had many, many malpractice files as counsel to the U.S.F. & G.

He attended Friends School in Baltimore, Lawrenceville Academy and Princeton, and graduated from the Law School of the University of Maryland in 1912, and has been a successful practicing attorney in Baltimore since 1912. He is a member of the firm of Bartlett, Poe & Claggett.

It is now my pleasure to call upon Mr. Bob Bartlett.

May I make a suggestion that the question period immediately follows Mr. Bartlett, and the ushers will collect them after Mr. Bartlett's remarks are concluded.

SUGGESTIONS TO FORESTALL MALPRACTICE CLAIMS

ROBERT D. BARTLETT, Esq.

Mr. Moderator, ladies and gentlemen:

You have heard the expression before, that the hour grows late. Well, I am going to curtail what I have to say, because the hour is growing late, and because I know you want to ask questions, and I, for one, am certainly intensively interested in what those questions will be.

There is not much left to be said from the legal standpoint after listening to Bill Macmillan's paper. He has given you the law of Maryland as laid down by the Court of Appeals pertaining to malpractice cases.

During the past ten years there has been a tremendous increase in the number of claims and suits filed against physicians in which the plaintiffs claim large sums of money for alleged damages suffered as a result of alleged negligent treatment by doctors. This increase has not been confined to any one section of the country but is nationwide and has become so bad in some states that several insurance companies have felt it necessary to discontinue writing insurance protection for physicians and dentists.

It, therefore, is of particular interest to those

of us who are amenable to such actions to take stock and see what we can do to prepare ourselves to adequately forestall and defend a malpractice suit. I am, therefore, taking the liberty of making some suggestions which may be helpful in forestalling a claim by one of your patients.

I had not heard Dr. Firor's paper, or Dr. Ullrich's paper, until this evening, and I was impressed by the fact that Dr. Ullrich's thoughts were following the same line as mine in this respect.

I believe from my observations that a large number of malpractice claims have their inception in some thoughtless and unguarded remark made by a doctor to a layman in criticizing or taking exception to the treatment or technique of some fellow member of his profession. This can happen at any time or place, but usually occurs when a layman changes doctors, for one cause or another.

I cannot over-emphasize the importance of keeping full and complete office records of what transpires at every visit of your patient.

When I am called upon to defend a physician who has been sued for alleged malpractice, the first thing I ask for is the doctor's office and hospital records pertaining to his care and treatment of the plaintiff. If the record has been conscientiously kept, final victory is fifty per cent assured.

All too frequently, however, the record is bobtailed to such an extent as to be of little assistance.

I realize only too well what a chore it is for a busy doctor to record what happens at each visit of the patient, but bear in mind when a claim is made against you it is very often a year or more since you last saw the patient. He or she now alleges that on a certain visit to your office, giving a certain date, you did so and so, or you said so and so, or recommended so and so, and is most positive and emphatic about it. If your record merely contains a notation that "Mrs. X was in, to come back in ten days," you are at a great disadvantage. The jury knows

that you have seen many, many patients since that important date and that you can have no actual memory as to what transpired on that day. Consequently, Mrs. X's statement is accepted, and an unnecessary defense burden is placed upon you. All treatments and prescriptions should be recorded and all statements of the patient as to how she is feeling.

If you have discussed the patient's condition with another doctor, be sure to record that fact on the chart. Two years later you might have forgotten the incident and possibly lost a helpful witness. Should you become exasperated by the failure of your patient to keep appointments or carry out your instructions concerning dieting, taking prescribed medicine or exercise at home, write her a polite letter insisting on complete cooperation and attach a copy to her history chart. Don't note your exasperation on her chart. Remember that should she sue you, all of your records pertaining to her case will be read to the jury.

Now, what should a doctor do when a claim is made against him by a patient?

Immediately notify your insurance company and make available to its attorney all your records. Prepare as detailed and as complete a statement of all the facts of your interviews and mental and physical examination of your patient as possible. Enumerate the causes and facts upon which your diagnosis is based, the treatment you prescribe and the progress made by the patient. Endeavor to explain the reasons that could have influenced your patient in becoming dissatisfied with your treatment. Consult any other physician who may have seen the patient, either separately or jointly with you. Ask him to reduce to writing all of the facts of which he has any information. Obtain a statement from your nurse or secretary, especially remarks she may have overheard the patient make in the office or over the telephone.

The next thing is to request the secretary of the Medical and Chirurgical Faculty to arrange

a meeting of a group of physicians who are particularly qualified to pass judgment on the particular matter about which the patient complains, and suggest the names of the physicians that you personally feel are best qualified to render assistance. Mr. Anderson, Mr. Macmillan and I have found these meetings to be tremendously helpful.

The meeting holds a two-fold purpose. First, the attorneys and the accused physician obtain the benefit and experience from the observations, suggestions and recommendations of the Committee; and as some of these doctors will be asked to testify for the defendant, they will from the start have become familiar with the facts of the case and the medical and legal questions involved. All information possible pertaining to the patient's background and medical history should be obtained; and while this work will largely fall upon the attorney, there is much that the physician can do to assist.

Those meetings that Mr. Macmillan mentioned are in my opinion of tremendous importance, because that is where the defendant's attorneys have the benefit of hearing opinions of some six or seven doctors who are specialists in the line of their practice pertaining to the particular subject that is being complained about. And it is there that we can form our opinion as to whether a case can be successfully defended or whether some effort should be made to compromise it.

I would recommend that you refrain from discussing or commenting on the claim with anyone except the persons whom you expect eventually to call as witnesses. And above all, try not to worry or let the matter get on your nerves. That is what you have a lawyer for, to take that burden off your shoulders.

I personally feel that it would be very wise

for a surgeon to obtain the written consent of his patient prior to performing any operation.

I realize that there are two schools of thought on this subject, some doctors contending that if they are consulted by a private patient who submits himself for diagnosis and recommendations of treatment and acquiesces in the doctor's recommendation of an operation, there is no necessity for a written consent. This may be perfectly true in a large number of cases, but the vice of this assumption is that should unhappy results follow, then a question of fact arises which presents a question which must be submitted to a jury; and the surgeon is subjected to an entirely unnecessary hazard of a jury's opinion as to whether there has been an agreement for the performance of the operation or not.

I wholeheartedly agree with the opinion of the other school of thought, namely, that a surgeon should obtain the written consent of his patient or the patient's family to the performance of the operation. Should the patient be a minor and, therefore, unable to give a legal, binding consent, the approval of the parent or guardian should be imperative and should be insisted upon by the operating surgeon, as well as by the authorities of the hospital where the operation is to be performed. The failure to obtain this permission may be the only claim for damages, and the allegation is then one of assault, which is much more difficult to defend than a charge of malpractice.

*Calvert & Redwood Streets
Baltimore 2, Maryland*

MR. SASSCER: Thank you very much, Mr. Bartlett.

Your vast experience and extensive practice in this field have given you a background that enables you to give a presentation that has been most interesting and instructive.

QUESTION AND ANSWER PERIOD

MR. SASSCER: I would like to request Mr. Feldstein and Mr. Dorsey Watkins to act on behalf of the Panel, and collect such questions from the audience as they may have.

In the meantime, I believe if our Panel will proceed to the microphone, it may be a little easier.

While the questions are being collected, I have one question that was passed up to me. And I would like to ask Dr. Ullrich to start off the question period by answering it:

Q. The question is: What should be the attitude of the doctor when the patient and the members of the patient's family insist on discontinuing his services?

Dr. Ullrich, will you be good enough to take that question?

DR. ULLRICH: I believe that the doctor should cheerfully relinquish his patient, and he should discuss with the second doctor the course of the illness prior to turning over a copy of all of his records. He should do it cheerfully.

Q. MR. SASSCER: In other words, you feel that if the patient wishes to discontinue the services of the physician, he should turn over his records to the other physician?

DR. ULLRICH: Yes, I do.

MR. SASSCER: I have another question that has been handed to me, and which I will request Dr. Firor to take.

Q. What should be the attitude of the doctor who has been discharged to the other doctor?

That is a rather tough one.

DR. FIROR: It is a very practical question, however.

It seems to me that the first thing to do is to make certain that the first doctor has been notified of the patient's intention to change. We never accept a patient without being certain that the other doctor has been informed of the patient's intention.

The second thing to do is to ascertain the facts in this patient's illness, so as to make as

careful and accurate a diagnosis as possible and to outline the treatment that is best for this particular patient.

Now, this can be done with an aura of sincerity, and without the necessity of informing your predecessor.

If, however, you have reason to think that the first doctor was grossly incompetent, I think you are obligated to refer that to the Licensing Board next door.

As a matter of fact, this very week I had occasion to do just that.

For ten long months, a woman has been going to a doctor because of an ulcerated cancer of the breast. Weekly he gave her some sort of pill to take, and he told her that the cancer had ulcerated and was draining, the corruption would come out, and she would recover. I got that patient to fill out an affidavit and have it witnessed, and sent to the Board of Medical Examiners a description of the condition in which that patient came on my service at the Maryland General Hospital. It is gross negligence like that which the doctors should weed out.

MR. SASSCER: Thank you, Doctor.

That certainly carries continuity of accurate medical attention and care to the patient.

We have some more questions.

This question, before I read it, is directed to Messrs. Macmillan and Bartlett, and it is difficult for me to decide between you as to which of you should take it.

Q. The question is: What practical steps have been taken to insure that a person injured through malpractice can obtain competent and impartial medical testimony?

MR. BARTLETT: Bill, you take that. You brought the subject up.

MR. MACMILLAN: Who asked that question?

A VOICE: I did.

MR. MACMILLAN: I am glad to hear that, because I would like to direct the answer to you.

Well, as I said in my previous remarks, I

think that that matter is one of great importance, because, as strange as it may seem to laymen, and conceivably also to the medical profession, one of the objectives in the legal profession is to seek the truth. Of course, you cannot recognize that when the question is being asked, and when the gentleman who sits over there is on the bench, and also the other side is trying to get the truth, and you are trying to ask the question and elicit an answer, and the other side's lawyer says that he objects to it, and the Judge may sustain it—I think, therefore, that there ought to be some procedure set up whereby it can never be said that a plaintiff-patient, or a patient who is not yet a plaintiff, feels that he or she has been injured by reason of malpractice of a physician, that his or her attorney cannot in some way, shape or form have that question determined. And I think that possibly the Committee that has been set up to work with both the medical profession and the legal profession may have some procedure like that arranged by that Committee.

A VOICE: Bill, may I ask another question?

MR. SASSCER: No, you cannot. We cannot have a debate back and forth, and I think we can cover the subject more embracively if we go along in an orderly fashion.

MR. MACMILLAN: You see that. He was a member of the Maryland Senate, and also Speaker in the House.

MR. SASSCER: I might say that that is a very good question, and one that you lawyers frequently comment upon, and concerning which I think a good deal could be done.

MR. MACMILLAN: Let me say this, that I was reminded, and especially so by Dr. Firor, that there has been submitted to the Supreme Bench of Baltimore City a list of doctors who are considered by the Medical and Chirurgical Faculty of Maryland as being especially well qualified in every respect in the various branches of the profession. When the time arises for any of the Judges of the Supreme Bench of Baltimore City to call upon a doctor for an absolutely

independent and impartial opinion and advice, that list is available.

MR. WATKINS: That is after the suit is filed.

MR. MACMILLAN: Yes, after suit is filed. But, of course, I am thinking about before suit is filed. And that is what I think the question was intended to be.

I think there ought to be something done before a person has filed suit. In other words, if he has any doubt as to whether he has got a case or not, I think it would be well if something could be done about it. And I think there would be more suits in the Baltimore Courts than there are now if it were not for the fact that the lawyers here are careful indeed to examine the facts in every case before they go ahead and participate in the filing of a suit against a doctor.

Q. MR. SASSCER: In other words, Bill, your theory is not, "God bless the man who sues my client"?

MR. MACMILLAN: No, not in this instance.

No, I think it is a very good thing to have such an important question looked into, and I think the medical profession should try to get together and bring out something of interest in that regard.

MR. SASSCER: I have a question here relating to discs.

Q. What about the surgeon who chops up a back for a fee, under the diagnosis of a disc, when there are no symptoms of a disc.

Dr. Ullrich, will you try that one?

DR. ULLRICH: Mr. Moderator, I would say that if a man chops up a back, he should no longer have his license. I assume it means that he performs a surgical operation.

Will you read that question again, Mr. Moderator?

Q. What about the surgeon who chops up a back for a fee, under the diagnosis of a disc, when there are no symptoms of a disc.

That is the question. And then we have the word "malpractice" with a question mark after it.

DR. ULLRICH: I would say that he is not only

mistaken, but is certainly most energetic, and he would probably wish he had never seen that patient.

MR. MACMILLAN: Or the patient wishes that he had never seen the doctor. There is an equal thing there.

MR. SASSCER: We have a question here directed to the legal side of our panel, and I will ask Bob Bartlett to take this one.

Q. How frequently are malpractice suits settled out of court?

MR. MACMILLAN: Don't give away any information belonging to the client.

MR. BARTLETT: That is a good one.

A VOICE: And the company.

MR. BARTLETT: Well, that is true. Some companies do and some do not.

Q. MR. SASSCER: Will you tell us something about that question, Mr. Bartlett?

MR. BARTLETT: Yes. Will you read that question again, please?

MR. SASSCER: This is not directed to either side particularly, but generally.

Q. The question is: How frequently are malpractice suits settled out of court?

I assume it means what percentage of malpractice suits are settled out of court.

MR. BARTLETT: Well, I would say rather infrequently.

Of course, there are some malpractice claims that come to our attention as attorneys where it is perfectly obvious that the doctor has made a mistake. It is a mistake that he never intended to make but, nevertheless, a mistake has been made. No one is perfect.

And when a situation like that arises, I think it is a fair statement to say that if the doctor is protected by insurance, and if the claim is not entirely exorbitant, as so many of them are, and if a reasonable amount can be agreed upon, that claim is most certainly settled and does not reach the point of going to trial.

MR. MACMILLAN: That is provided, of course, the doctor agrees to it.

MR. BARTLETT: Of course.

MR. MACMILLAN: There is that reservation.

MR. BARTLETT: Of course, from an insurance standpoint, the doctor must give his written consent before even one penny can be paid in settlement of any claim.

Q. MR. SASSCER: Is that a provision of the policy?

MR. BARTLETT: That is a standard provision of all malpractice policies, as far as I know.

Q. MR. SASSCER: When the insurance company writes the policy, does the policy contain a provision that they cannot settle it without the written consent of the doctor?

MR. BARTLETT: As far as I know, that provision is contained only in physicians', hospitals' and dentists' insurance, and it does not apply, of course, to the ordinary liability policies or any other kind.

MR. BENJAMIN L. WOLFSON: And lawyers' policies.

MR. BARTLETT: And my attention is called to the fact that it is also in policies carried by lawyers who carry a malpractice policy.

MR. SASSCER: Now, Dr. Firor, I would appreciate your taking the next question.

Q. Is it required or advisable that a physician recognizing malpractice by another physician, inform the patient of this fact?

DR. FIROR: That is really two questions.

The first is, is it required that a physician inform his patient. The answer is no, it is not required.

The second question is, is it advisable for the physician to inform the patient that he thinks another physician has been guilty of malpractice. That is purely a matter of judgment. I can think of circumstances in which I would tell that patient straight from the shoulder, without any hesitation, that in my book what he had been subjected to was malpractice! period! And I would do that on behalf of the patient.

There are other circumstances in which I would not consider telling the patient, because malpractice is not an entity. When I think of malpractice in terms of deliberate disregard of

the patient's welfare, or dishonesty on the part of the doctor, then I think the patient is entitled to know. If, however, the doctor has made a mistake, or has been a little careless—and who of us has not been—there I think no good comes from telling the patient.

MR. SASSCER: Mr. Macmillan, this question is apparently somewhat of a legal one, so I will ask you to listen to it and answer it.

Q. Can a wife sue a physician who has performed a sterilizing operation on her husband?

MR. MACMILLAN: Well, we would have to have some factual data as to how well they got along together in various and sundry ways. As you all know, there is such a thing as *damnum absque injuria*. The question is very plain, and I do not think I should answer it. That, of course, is injury without damage.

MR. SASSCER: Here is a question which I will ask Mr. Bartlett to answer.

Q. Would an expert witness who practices in the District of Columbia be a competent witness in a suit against a Baltimore surgeon?

MR. BARTLETT: Well, if he has any facts about the case that he knows personally, he would certainly be allowed to testify. The fact that he lived in Washington would not disqualify him from testifying in Baltimore.

MR. SASSCER: This question is also directed to the hypothetical phase of it, as well as the usual and ordinary situation in the community.

MR. BARTLETT: If a hypothetical question is put to a Washington doctor as to what happened in the treatment of a patient in Baltimore, and the doctor had been present in Court and had heard all of the testimony that had been given, even then I do not think he would be or should be allowed to answer the hypothetical question unless he further qualifies himself by assurance that he is very familiar with what the custom is in Baltimore, and what the standard of practice is here, and how the members of the medical profession conduct themselves here in Baltimore.

If he can cross those hurdles, the fact that he

lives in Washington I do not think would enter into it.

Personally, I have never known a doctor from out of the state brought in and put on the witness stand here in Maryland and asked a hypothetical question when he does not know anything about what has transpired in the treatment of the patient.

MR. SASSCER: Dr. Ullrich, here is a question which I will ask you to take.

Q. If you knew as a matter of fact that a fellow doctor had not used the care prescribed for the treatment of a patient, would you testify against him?

MR. MACMILLAN: Do you want me to object to it, Doctor?

A VOICE: Do you want to talk to your lawyer?

MR. MACMILLAN: We object.

A VOICE: I think that is a loaded question.

DR. ULLRICH: I would certainly want to know all the facts, and what difference there would be in the outcome in the treatment of the patient.

Q. MR. SASSCER: Would you repeat that, please, Dr. Ullrich?

DR. ULLRICH: I would want to find out all the facts with regard to that particular patient, and whether I would have done anything different, or whether it would have made any material difference in the outcome of the patient.

Q. MR. SASSCER: I think this question is based upon the premise that if you knew that the doctor had not used the care prescribed for the treatment of the patient, would you testify against him?

DR. ULLRICH: I would say that I would hope I would never be called upon to testify.

MR. SASSCER: Dr. Firor, we have another question directed to the doctors.

Q. Is a doctor compelled to respond to every call?

Would you please answer that question Dr. Firor?

DR. FIROR: No. He is not compelled.

Q. Would you care to elaborate on that, or do you want to just leave it as no.

DR. FIROR: Yes, I will elaborate on it. A doctor is not obligated to accept every patient that comes to his office, or every call that comes over the phone.

It is just good, sound common sense to realize that there is a point really beyond which a single person can go, in what he has to do, and many times it is physically impossible for a doctor to take on additional patients. And he is, therefore, for that reason alone, justified in saying no.

MR. SASSCER: Mr. Macmillan, here is a question which I will ask you to take.

Q. Isn't it true that the reason so few law suits are filed against physicians, and so forth, is because so many are settled out of court?

MR. MACMILLAN: Well, I do not admit in the first place that there are so many suits filed against physicians.

I say that with respect to my own experience over a period of some years. And while I know that there seems to be today more suits or claims against the doctors, I do not regard it in Maryland as particularly alarming.

It certainly has not reached the stage I think in Maryland where the doctors ought to feel, or have any ill will against the lawyer who brings the suit.

What is that question again, please?

Q. Isn't it true that the reason so few law suits are filed against physicians, and so forth, is because so many are settled out of Court?

MR. MACMILLAN: I think it is the other way around, because we do not settle them. There are many claims that are brought and no settlement made at all after the suits are filed, and they have never come to trial. Believe me, there are a number of claims like that.

And please understand that more often than not, we find ourselves representing a doctor who has brought it in to us, where the doctor has been sued for malpractice, and he is fighting mad about it, and when settlements are made, they are made lots of times after we have persuaded the doctors to make them. And I want

it to be understood that the settlement of a malpractice suit is not an admission of liability.

I don't know whether that answers the question or not.

A VOICE: Yes.

MR. MACMILLAN: Is that all right?

A VOICE: Yes.

MR. SASSCER: Dr. Firor, we have this question for you.

Q. What is the status of a physician whose patient refuses referral to a specialist (psychiatrist) in a field outside his scope, and insists on treatment by the physician in spite of protest?

This is just the reverse of where the patient wanted to leave the physician.

DR. FIROR: That is a very real situation. Unfortunately, many people think mental illness is a disgrace, and they resent the family doctor suggesting a psychiatric consultant. That happens every week in this city. The problem resolves itself in this way, I think. Is the mental illness of such severity that the patient might do harm to himself or to some other person, or is it a minor psychosis? Now, if it is a major psychosis, in which the patient has suicidal or homicidal tendencies, then the doctor is obligated to call in two practitioners who have been licensed in the state for five years and they can sign a petition of commitment, which will enforce that patient's admission to the psychiatric hospital for diagnosis. If, however, it is a matter of convenience to the doctor, or if it is a minor psychosis, then I think it is probably good judgment to go along with the patient's wishes.

Q. MR. SASSCER: If the patient does not wish to continue on with his physician, even though it may not be in the best interest of the patient, do you feel it would be wise to urge him to have further treatment?

DR. FIROR: Yes. It is a matter of judgment. You cannot generalize.

Q. MR. SASSCER: Even though it might be helpful?

DR. FIROR: Yes. Many times a psychiatrist could help to shorten the patient's illness and

give that individual patient the help which the family doctor cannot give, but you cannot stuff advice or help into an unwilling patient's mind.

MR. SASSCER: Mr. Bartlett, I will read this question just as it is.

Q. Considering the personal nature of psychiatric records, could such records be read in Court?

MR. BARTLETT: Read that again, please.

Q. Considering the personal nature of psychiatric records, could such records be read in Court?

I assume this means, are they confidential?

MR. BARTLETT: No, I do not think they are confidential to the extent that if a person happened to be in Court because of psychiatric trouble and had been examined by a doctor, the doctor's records may be examined, and he may be examined on this, and it may be read in Court as part of the record of the case.

Q. MR. SASSCER: I think it is correct, is it not, that the communication of the doctor is not privileged, and that the doctor is subpoenaed.

MR. BARTLETT: Yes, that is right.

MR. MACMILLAN: Where everybody is present, the only communication that is privileged is a communication between the client and the lawyer. If you have serious mental problems, talk to your lawyer about them, and he can talk to the doctor, you see, and nobody can get it out of him.

Q. MR. SASSCER. Dr. Ullrich, if a patient disagrees with the line of treatment, can the doctor dismiss the patient without his consent?

DR. ULLRICH: I believe he should and could.

MR. SASSCER: We have not heard Mac for some time. Let us see if we can find one for him.

MR. MACMILLAN: Oh, might I break in once in a while?

MR. SASSCER: Here is one directed to Mr. Macmillan.

MR. MACMILLAN: I can tell them the story about the two fingers. Don't anybody walk out!

Q. MR. SASSCER: Would the fact that a dentist

allowed a drill to slip and injure a patient be enough to constitute negligence, in the absence of any proof of how it happened other than the mere happening itself?

MR. MACMILLAN: Oh, no.

MR. BARTLETT: No.

MR. MACMILLAN: You have all read about the maxim that there is no presumption. There is no *res ipsa loquitur*. The thing does not speak for itself. That is merely the occurrence of an accident. And there is nothing particularly peculiar about physicians and surgeons. That same thing applies to an automobile accident and that is that the mere happening of the accident raises no presumption of negligence against the driver. And the burden rests upon the plaintiff to prove by a preponderance of the evidence that there was negligence.

Now, that is the logic you get in negligence cases in automobile accidents, and malpractice is certainly nothing more than negligence.

Q. MR. SASSCER. Mr. Bartlett, is it true that an insurance company will refuse to continue coverage on a doctor once a claim is made against him? (Even if the physician wins the case.)

MR. BARTLETT: No.

MR. SASSCER: As long as you got off so easily on that one, with such a short answer, we will give you another question.

Q. If there has been so little malpractice in Maryland, why have the insurance rates gone up in recent years so much?

MR. WOLFSON: That is a good one.

MR. MACMILLAN: I cannot make any profit on that.

MR. BARTLETT: Mr. Moderator, I am not an insurance underwriter. I don't know. I frankly don't know what makes rates go up. But I suppose the rates are going up because everything else that I buy has gone up.

MR. SASSCER: Well, that is probably a good answer.

MR. MACMILLAN: I think they are going up because we lawyers are charging higher fees.

A VOICE: Well, we are not getting any higher fees.

MR. SASSCER: Mr. Macmillan, if a surgeon leaves, or an intern,—it looks like if a surgeon leaves an intern and other foreign matter—

MR. MACMILLAN: Well, there have been questions about leaving a saw and hammer inside a patient, but I don't know about an intern or other foreign material.

I guess that is some of those foreign injuries that we hear about around here. Go ahead. Well, they are small enough, some of them.

MR. SASSCER: Well, at least some of them that I have seen would be difficult to be left in.

MR. MACMILLAN: I know of some surgeons who would be afraid to go to the operating table, because they would be afraid they would fall in, and for some of these big operations, perhaps they should have big doctors, or streamline the operations that they have.

Well, what has happened to the question?

Q. If a surgeon leaves, or an intern, leaves foreign matter, or other matter, in the place of an appendix, would you say that no negligence is involved?

MR. MACMILLAN: Well, the question presupposes that there should be something left in substitution of the appendix. Well, I don't know. I do not think that is a hard one, one that we should be afraid to bring in. I do not think we ought to feel afraid of that one.

MR. SASSCER: Mr. Bartlett, I do not want to seem to be picking on you, but this question is directed to you.

Q. Are the Committee meetings of which Mr. Bartlett and Mr. Macmillan spoke held at the expense of the insurance company? How can a plaintiff afford himself of the same opportunity?

MR. BARTLETT: Well, expense has never gotten into it. I don't know of anybody who has ever paid a nickel of expense, and it is only the expense of coming up here and attending any of the meetings that we have held when we are discussing any particular claim that has been made against a doctor.

Now, the second part of that question is getting back to what has been asked several times here tonight, and that is what can a claimant, a plaintiff, or a person who thinks he has a valid claim against a physician do to get medical advice?

Well, they can go to a doctor. And I would suggest that they go to the most reputable doctor that they can find and place all the facts in front of that doctor, explain the entire situation, and then be guided by that doctor's advice.

And I think that if that would be done there would be a very great decrease in the number of claims that are made against physicians, surgeons and dentists.

A VOICE: As Dr. Ullrich said, he hoped he would not have to testify.

MR. WOLFSON: He said he hoped he would not have to testify.

MR. MACMILLAN: Is Charles H. Meddus still in practice, because he is a lawyer and doctor.

MR. SASSCER: Mr. Macmillan, here is a question for you.

Q. How do you get a doctor to testify for the plaintiff in a malpractice suit?

MR. MACMILLAN: Well, how do you get any physician? Well, you go to him and ask him if he will come, and if he will not, then you must subpoena him.

If you go to any witness and ask him to testify, and he says no; suppose you go to an architect, or a civil engineer, or somebody else, you go to him and ask him to testify, everyone of them I am sure will come into Court and testify.

Q. A VOICE: Let us reverse the question. What would you do if there were a lawyer who wanted to sue another lawyer, what would you do, ask yourself the question, would you get another lawyer to come in and testify?

MR. MACMILLAN: Yes, some lawyers will and some will not.

MR. SASSCER: Mr. Macmillan, this is directed to you.

Q. What about injuries caused by the negligence of nurses?

MR. MACMILLAN: Well, one of the very best lawyers that represents nurses that I know of is Douglas N. Sharretts. He had a case where George Flentje represented the plaintiff, along with another lawyer. And Andy Anderson appeared on the defendant's side. And Doug Sharretts represented the nurse. And the nurse got out scot free. And she was a practical nurse.

A VOICE: Says you.

MR. MACMILLAN: What is the reference again to the practical nurse? How do you get a nurse to testify?

MR. SASSCER: Have there been many such suits instituted?

MR. MACMILLAN: Against nurses?

MR. SASSCER: Yes.

MR. MACMILLAN: Yes. And in this last case of Kalives, she was represented by Charles H. Meddus, who was her lawyer, and he was also a doctor. And, believe it or not, he got up from the trial table and took the witness-stand, before Judge Saylor, and propounded to himself a hypothetical question. And you can read it yourself. It is in 177 Maryland. And he got the question in. There were a number of such questions. And the Court of Appeals seriously considered them. They did not make fun of them. They just seriously considered them.

And in that case they sued not only the Baltimore Eye, Ear, Nose and Throat Hospital, but Dr. Lee Cohen, the internist, the assistant, the nurses, the superintendent, the coroner, and other gentlemen.

Isn't that true, Mr. Tschudi?

MR. TSCHUDI: Yes, that is true.

Q. MR. SASSCER: Here is a question asking if the doctor is responsible insofar as liability because of injuries caused by the negligence of the nurse.

MR. MACMILLAN: Well, in the Hunner case it was very definitely and positively and em-

phatically held that a surgeon is not responsible for the acts of either the interns, nurses or the orderlies who are employees of the hospital.

A VOICE: That is his own nurse.

MR. MACMILLAN: Well, then the question is one of principal and agent, or respondeat superior. But the question is, can the surgeon be charged with the negligence of the nurse, where they are taken to the hospital, and he does not have anything to do with the hospital personnel. The answer is no.

MR. SASSCER: I do not understand this one. It is signed, "Little Abner." It says, "Dear Mac, Don't forget to tell the two finger story."

MR. MACMILLAN: That is all right.

Q. MR. SASSCER: Mr. Bartlett, do you find any cases where suit has been entered against a naturopath or chiropractor?

MR. MACMILLAN: Isn't a naturopath something like a nudist?

MR. BARTLETT: I don't know what a naturopath is. I personally have never had any contact with such a case or such a claim.

MR. SASSCER: Dr. Firor, there are many questions in the group here that relate to the question of malpractice, and I think rather than to take up the individual ones, perhaps you could discuss the existence of such a group and the availability to the people as far as the presentation of their cases is concerned.

DR. FIROR: I take it that the members of the Bar are interested in a question such as this.

Q. MR. SASSCER: I take it that they are. I did not quite fully describe what I had in mind. It is primarily directed I think to finding if there could be a panel of medical experts to review the situations involving malpractice, in order that the plaintiff might have the same benefit in obtaining medical testimony in his case that the defendant has.

DR. FIROR: Yes. Some years ago the Medical Faculty realized the need for such a panel, or such a group, and there was created what was known as the Grievance Committee—a group of older doctors who were appointed by the



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The term Grievance Committee is not too happy a one. And recently the Committee has been designated as a Committee on Professional Care or Professional Relations. In other words, there exists right now in this faculty a committee of doctors who have agreed to serve and who will study complaints about doctors that are sent up by laymen.

Q. A VOICE: Will they testify?

DR. FIROR: I cannot answer for them, because I am not one of them.

Q. A VOICE: Will they give a written report on such a question? Will they give a written report when requested?

DR. FIROR: Yes, they give a written report, because they are willing to give their time to hear a patient's complaint against a doctor. They should not be necessarily subpoenaed to testify in those cases. And I think it is very generous of those men to do that. And many times they can be of a very real service to the plaintiff.

Q. MR. SASSCER: Doctor, to project that one step further, suppose there was evidence of malpractice, and those physicians had generously given of their time, and the case has to go on to the Court, and in line with the law as outlined by Mr. Macmillan a while ago, and you would want to have some medical testimony to substantiate your malpractice, do you think there should be, or could some situation be developed

in which doctors might be available to testify for the plaintiffs in cases of that kind?

DR. FIROR: I can only answer that as an individual.

I certainly would not want to go on record as permitting or even implying any commitment to the members of that Committee.

Personally, if I would be convinced that there was malpractice and I was asked to testify, I would go and tell the truth, period.

MR. SASSCER: Thank you, Doctor. I think that answers the question.

DR. FIROR: But I want it definitely understood that that in no way implies any commitment from any member of this Committee.

MR. SASSCER: Several questions have been asked in the group here as to why there are no plaintiffs' lawyers on the panel.

Well, the Committee chose the lawyers, and they felt that the experience of these two gentlemen who are here and who were selected fell into a field to which our inquiry here tonight is directed, and so, therefore, they chose the gentlemen whom they considered to be well versed in this particular entity.

As the Moderator, I want to thank you for coming here tonight. And I think I express your feelings in thanking the doctors and the members of the panel who have come here and given us enlightenment in this matter. We want to give them our appreciation for their participation in the discussion.

ARTICLES OF INTEREST

NOT FOR SOCIALISTS

AMOS R. KOONTZ, M.D.

There are people who honestly believe in socialized medicine and other forms of socialism. That is, unquestionably, their privilege under our democratic system. There are others who do not believe in socialism in any form. I happen to belong to the latter group. It is unquestionably, also, under our democratic system, our right, privilege and *duty* to air our views and to combat a system which we believe would be bad for our country.

The General Assembly of Maryland has passed a resolution memorializing Congress not to federalize the practice of medicine. The Baltimore City Medical Society and many of our county societies have gone on record as being opposed to socialized medicine. Our State Society has done the same thing. It seems, therefore, right and proper for a member of that society to point out some of the methods and means which we can use to prevent socialized medicine or socialism in general from being thrust upon us. Medical Societies may not engage in politics. By this is meant that they may not take sides on purely political issues and may not advocate the election of one candidate over another. They may, however, with perfect propriety express their views with regard to any issue which is to come before a legislative body. These views may be expressed either jointly by the society as a whole, or individually by component members of the society. Component members, of course, when not acting as agents for the society, may engage freely in the hurly-burly of politics, and in my opinion they should. The physician's duty as a citizen even transcends his duty as a physician, even taking into consideration the high plane on which we all consider the latter duty should be held. If we are false to our country, how can we be true to our profession, or anything else?

One of the most effective agencies in the entire country for combating socialized medicine and allied socialistic schemes is the Association of American Physicians and Surgeons. This organization, very properly I think, comes out flat-footedly against

socialism in all forms. It is idle to fight socialized medicine alone or to single out any other phase of socialism as a target. A country can no more remain a little bit socialistic than a woman can remain a little bit pregnant.

The AAPS sends out frequent bulletins to all its members keeping them thoroughly informed of any socialistic or other measures which are introduced in Congress that are inimical to the interests of our profession and our country. It also furnishes the names of the members of the Committees handling these bills, so that its members may write, not only to their own Senators and Congressmen, but to the various committee members urging them to vote against the bad bills.

No individual can possibly keep himself informed on all the things going on in Congress, or when important votes are coming up. The AAPS effectively performs this service for its members. An example of a result of their concerted action was when the House Committee recently reversed itself, within a few days, on compulsorily including physicians in the Social Security Program. It is hard to understand why anyone should want to put physicians into this iniquitous system against their will, unless it is a part of a general effort to thrust total socialism upon us. If physicians were included, it would simply mean that they would have their tax burden added to materially, in order to receive a monthly pittance at the age of sixty-five, *provided they stopped work*. Can anyone by any stretch of the imagination call this sort of compulsion freedom? The AAPS undoubtedly played a large role in causing the House Committee to reverse its decision in the matter. Of course the AMA was against it also, but the AMA sends its information only to a selected group of members, while the AAPS sends its News Letters to *all* of its members.

Many other examples of the effectiveness of the AAPS could be cited. One is the recent defeat of the scheme to put the Federal Government in the re-insurance business. The tremendous advance in American medicine over the past fifty years, both in the field of scientific medicine and in the domain of caring for the health of our citizens, shows that

the free enterprise system has worked beautifully, and it is hard to see how it could be anything but slowed up by government meddling. Furthermore, the rapid and continued spread of health insurance schemes, both voluntary and private, is phenomenal. There is little, if any, need for re-insurance in the health field, where the amounts involved are small, as contrasted to the large amounts involved in life insurance and where re-insurance is the rule among private insurance companies. Had the Federal scheme been put into effect, the chances are that it would have been used only as a sort of Federal subsidy to reinsure "bad risks" business. It would also unquestionably have been an entering wedge to government control of health, and, therefore, a precursor to complete socialized medicine.

The AAPS has consistently refused to compromise on the basic principles of free enterprise, and has steadfastly held out against the encroachment of socialism in any form. It has constantly resisted attempts at Federal aid to medical education, non-service connected Veteran medical care, and other socialistic programs. The Federal encroachment has been an insidious piece-by-piece affair, purposely done so that it would hardly be noticed. Unless the political planners are carefully watched by someone, we will eventually be completely Federally controlled. And remember that the Supreme Court has ruled that what the Federal government subsidizes it may control. This should indeed make us wary. It has often been said that doctors should stay out of politics. We couldn't if we wanted to, and certainly a great many of us would not want to, but whether we like it or not, we have been thrust into politics by the actions of the political planners who are endeavoring step-by-step to restrict our local self-government.

By this time the reader is probably convinced that this is a plea for all members of our Society who do not believe in socialism to join the AAPS. That is just exactly what it is. Those who do believe in socialism will not be interested, because the AAPS is out to fight socialized medicine and all allied forms of socialism, and of course all forms of socialism are allied. The AMA is carrying on a good fight, but its fight is principally confined to national and state central organizations. Furthermore, its fight is confined to those forms of socialism which affect the Medical Profession directly. The AAPS is trying to

make every member of the Profession all over the country a part of its crusade against socialism in all forms whether it affects the Profession directly or indirectly. Of course, there is no form of socialism which does not affect the whole country with a tremendous impact, and when the country is affected, our profession is affected. However, all of us should take the broader view that the country is what comes first, and we should oppose whatever is bad for our country, regardless of its effect on our profession. I think, however, that the interests of the two are identical.

I strongly believe that in the crucial times through which we are now passing, when during each session of Congress we see iniquitous bills introduced, that every member of the Medical Profession should belong to the AAPS, and join in the fight to keep our country out of the hands of those who are using socialistic schemes, not as a means to help people, but as a means to increase their own greed for power. To be eligible for membership one has only to be a member of his own local medical society. The dues are only ten dollars (\$10.00) a year. The return is many times that. Those who want to join may join by writing to the Association of American Physicians and Surgeons, 360 North Michigan Avenue, Chicago 1, Illinois, or by writing to the present writer. The time to act is *now*.

1014 St. Paul Street
Baltimore 2, Maryland

UNITED EFFORT IN POSTGRADUATE MEDICAL EDUCATION¹

DOUGLAS D. VOLLAN, M.D.²

EDITOR'S NOTE: A meeting was called on Thursday evening, August 5, 1954, at the Sheraton-Belvedere Hotel by Dr. Howard M. Bubert, Chairman and Director of the Postgraduate Committee of the University of Maryland School of Medicine for the purpose of attempting to coordinate the efforts of various groups in the State with regard to postgraduate medical education.

The meeting was presided over by Dr. Bubert. Dr. Doug-

¹ Presented at a Meeting sponsored by the Postgraduate Committee of the University of Maryland School of Medicine, August 5, 1954. Funds for the promotion of Postgraduate Education in the State of Maryland donated by the Hearst Corporation.

² Assistant Secretary, Council on Medical Education and Hospitals, AMA.

D. las Vollen, of the Council on Medical Education and Hospitals of the American Medical Association, was the guest of honor and principal speaker. Other guests were Dr. William S. Stone, Director of Medical Education and Research, University of Maryland; Dr. Harvey Stone of the Council on Medical Education and Hospitals of the American Medical Association; Dr. Theodore E. Woodward, Professor of Medicine and Head of the Department of Medicine, University of Maryland; Dr. George H. Yeager, Professor of Clinical Surgery, University of Maryland, and Editor of the Maryland State Medical Journal; Dr. Bender B. Kneisley, President of the Medical and Chirurgical Faculty of the State of Maryland; Dr. Lauriston L. Keown, President of the Maryland Academy of General Practice; Dr. Conrad Acton, President of the Maryland Academy of Medicine and Surgery, and representing also the Baltimore City Medical Society; Dr. Samuel P. Asper, representing the Johns Hopkins Medical School; Dr. Edwin H. Stewart, Chairman of the Postgraduate Committee of the Medical and Chirurgical Faculty of Maryland; Dr. Nathan Needle of the Maryland Academy of General Practice; and Dr. William Schuman of Doctors Hospital. The following members of the Postgraduate Committee of the University of Maryland School of Medicine were also present: Dr. Frank H. J. Figge, Professor of Anatomy; Dr. Louis A. M. Krause, Professor of Clinical Medicine; Dr. Harry M. Robinson, Associate Professor of Dermatology; Dr. Allen Fiske Voshell, Professor of Orthopaedic Surgery; and Dr. John A. Wagner, Associate Professor of Pathology.

It was the consensus of opinion of the assembled group that there was definite need of a coordinated postgraduate program and it was agreed that the suggested temporary organizing committee would be the step in endeavoring to accomplish this purpose. It was also requested that the problem be presented to the Medical and Chirurgical Faculty by Dr. Bender B. Kneisley.*

Your invitation to come to Baltimore was most welcome, since the subject is one that has occupied most of my attention in recent years. I hope that in some small measure the results of our nationwide study of postgraduate medical education may be of help to you in solving your local problems in this field. It is most encouraging to see such a group as this assembled on a summer evening to delve into one of the most difficult problems in medicine today—the continuing education of practicing physicians. Postgraduate education is not new in Baltimore, for as early as the 1880's there were some excellent opportunities for postgraduate study in this city. Since then, as in many other areas of the country, this phase of medical education has had its ups and downs here. It is to be hoped that from the kind of interest shown in a meeting such as this the future trend will be consistently upward.

* See Editorial by Dr. Kneisley in this issue of the JOURNAL.

Before going into the local problems, I should like first to touch upon some general considerations of postgraduate education. These factors are basic to the whole field and undoubtedly are important to some degree in this area, since they are characteristics of the national scene.

GENERAL CONSIDERATIONS

In recent years it has become increasingly apparent that graduation from a medical school is not the end of a physician's education. Some have gone so far as to consider it but the beginning, which from the point of view of years is certainly true for those who take graduate training in the form of residencies or fellowships. However, even this advanced study does not result in a final finished product. In fact, it is now realized that there is no end to medical education for the conscientious physician. Instead of a four year process, the physician's education is more likely to be a forty year undertaking.

Excluding formal graduate education entirely from this discussion, what *are* the methods by which a physician continues his education? Probably the most important, at least from the point of view of time spent in the activity, is reading medical books, journals, and other medical literature. Of similarly great importance is the time physicians spend in professional contacts with consultants, colleagues, pharmacists and detail men. Then there are hospital staff meetings and conferences, as well as attendance at medical society meetings of various kinds. And finally, formal postgraduate courses. In our survey it was found that among the large group of physicians who responded to a questionnaire on the subject, reading and professional contacts accounted for the largest amount of time in the overall process of continuation education. However, it is important to note that the responding physicians felt that second only to reading, postgraduate courses were the most effective method of continuing their education. Postgraduate education had already become a regular part of the professional life of many physicians, and as it becomes more widespread, and as it improves in quality, there is every indication that more and more physicians will take advantage of such opportunities.

This need for more postgraduate opportunities varies considerably from one region of the country to another, there being a gross disproportion between

the size of the physician population and the postgraduate opportunities in different areas. Not only is there a general maldistribution, but there is also a marked tendency to concentrate the opportunities in large cities. There is no area of the country that would not do well to expand the number of courses available; but more urgent perhaps would be a more adequate distribution of the present opportunities.

Of equal importance to these purely quantitative considerations is the need for a clarification of the objectives of postgraduate courses. All too often courses are set up with no purpose, and designed for no particular group of physicians. If postgraduate education is to develop along sound lines it is necessary that specific, well-defined objectives be set up for every postgraduate course. Such planning will make possible a more realistic and adequate coverage of the various fields of medicine, some of which presently are being very poorly covered while others enjoy a surfeit of opportunities. The field of general practice is especially lacking in coverage, and it is here that the need is probably the greatest.

Much criticism has been levelled at physicians for their lack of interest in continuing their education. Some of this is undoubtedly justified, as there are some doctors who are quite content to go on practicing the way they have since graduation. However, one of the most important aspects of postgraduate education, which has been given too little attention in the past, is an understanding of the students for whom it is intended. Here we are not dealing with a "captive audience" as is the case with medical students or residents with clearly defined goals to their training. Not only is postgraduate education a purely voluntary business with no rewards in sight, but the physicians who make up the student body in this phase of medical education are an extremely diverse group, with marked differences in background, type of practice, interests and needs. The nature of these differences also varies from one area of the country to another, so that in any given area it is necessary to analyse the characteristics of the local physician population before a sound postgraduate program can be developed.

Such a study of the potential students in an area will result in answers to many of the questions about the organization of postgraduate courses. Whether to use the concentrated or intermittent type, what length the courses should be, seasonal preferences, as

well as the desirability for intramural or extramural programs can be decided on the basis of such study.

The methods being employed in postgraduate education are more often than not based upon expediency alone. Since attendance numbers have come to be the index of success in postgraduate education, it is only natural that didactic teaching has dominated the field. There is little doubt that the lecture has a somewhat greater place in this phase of medical education than in the undergraduate or graduate years. But the consensus of medical educators, as well as the views of the physicians in our survey showed that there is a real need for a shift of emphasis from didactic teaching to more *participative* learning methods in postgraduate courses. This of course means smaller instructional groups which in turn means additional faculty time for a similar number of hours of instruction. This undoubtedly will pose serious problems in some medical schools, where faculties are already heavily burdened, but if postgraduate education is one of the basic parts of the whole process of medical education it must be given the same serious consideration that the other parts have received.

Needless to say, all of this requires money, and it is gratifying to see from our study that most physicians feel that the basic financing of postgraduate education should ultimately be their own responsibility. This being the case, it is but an administrative problem of finding ways of transferring the costs to the doctors. It should be possible for postgraduate medical education to pay its own way in the long run.

THE LOCAL PROBLEM

Although any one of the various problems referred to might well form the basis for discussion, I understand that the overall administrative situation is the most vital concern here at the present time. This is perhaps the best place to start anyhow, inasmuch as a settlement of this part of the problem will probably lead to the solution of many of the others. If we can judge by the experience of other groups in the country, it is almost inevitable that as sincere concern about postgraduate education develops in the various institutions and organizations within an area they will eventually come together in a meeting such as this to seek a common solution. With the numerous groups engaged in postgraduate education

in every part of America, it is to be expected that there is considerable overlap and duplication—if not frank competition—in this field, to the ultimate detriment of all. Not only is this uneconomical, but the net result is less than optimum quality programs. If this problem exists in this area perhaps the experience of others who have solved it in their own regions will be of some help to you. Whatever I can tell you at this time is based on an analysis of the approach to this problem by several other groups in the country. Since each area has its own unique problems, the outline given here will attempt only to deal with general principles, which may underlie a solution to the situation.

One way to solve the problem would be to develop a postgraduate institute with the overall objective of promoting, stimulating and coordinating broader and more efficient use of postgraduate education in this area. Basically such an institute could act as a clearing-house of information in this field, and the agency through which long-term objectives to meet the total postgraduate needs of the area could be realized. There is ample precedent for such cooperative action in many places, and it is of interest to note that these are generally places where unusually strong programs have developed.

Michigan was one of the first states in which the medical schools and medical societies joined forces to produce one of the finest postgraduate programs in the country. Several other states followed this lead and found that some of the seemingly insurmountable organizational problems they had faced were markedly reduced in size, allowing them more time to concentrate on the quality of individual courses. In recent years Massachusetts has developed a Postgraduate Institute that has served as a central coordinating agency for the three medical schools and other groups in the state who are interested in postgraduate education. The unique feature of this program is that it has successfully brought to bear upon the total postgraduate needs of the state the entire educational resources of a great many diverse institutions and organizations.

Such an institute in this area might develop along lines similar to those in Massachusetts since there are a large number of groups involved here as in that state. A commission made up of representatives from each of the medical schools and other organizations concerned with postgraduate education might

act as the governing body of such an institute, which could then employ a staff to carry out its program. Such a staff could work with and through the postgraduate divisions of each of the participating institutions and organizations.

The activities of such an institute could be directed toward aiding the member organizations in planning their programs, as well as helping the consumers—that is the physicians themselves—in their search for adequate postgraduate training. The primary function would be to act as a clearing-house for information on postgraduate education, through which it would be possible to coordinate and integrate existing activities, keep physicians informed of the opportunities in the area, and finally develop postgraduate programs in those areas and fields of medicine which are not presently being met.

To be of optimum value information would have to be collected on both the postgraduate needs of the area and the educational resources of the area. This would necessitate two different kinds of surveys. One would require a canvass of physicians to determine their content needs as well as their preferences for various time and place arrangements for courses. This could be supplemented by morbidity and mortality data available through the health departments in this area. The other survey would develop a complete file of the faculty resources available in each field and the facilities for postgraduate courses in the area. This would include data on courses presently being offered by the participating groups.

With this information it would be possible for the institute to integrate and coordinate the existing postgraduate activities by means of consultations with organizations whose courses overlap in content, time and place arrangements or in faculty usage. Control of the activities of these organizations would not be necessary inasmuch as making known conflicts and duplications of effort will in most cases allow for remedial action directly, since such voluntary action would be in the interests of each of the organizations involved.

Information collected by the institute could be the source of an overall catalogue of postgraduate opportunities available to physicians. Such a list could be published periodically and supplemented by schedules of hospital and medical school staff and departmental meetings to which practicing physicians are welcome. Beyond this, the institute could

help individual institutions plan postgraduate programs as such advice is needed. Eventually, through its overall view of the needs and opportunities in the area the institute would be in a position to point out the fields of medicine, the various physician groups, and specific geographical areas in which courses are needed. And as cooperation between the participating groups became more firmly established, some may wish to delegate the planning of these additional courses to the institute, thus relieving themselves of this added burden.

Benefits of such a program would be shared by the entire community. The medical schools would be assured of a more economical use of the time of their faculty members through the elimination of wasteful duplication and overlap in courses. Furthermore the total burden of postgraduate education could be distributed among the various schools more equitably than at present. There would be savings to all institutions and organizations giving postgraduate courses through reductions in publicity costs, minimizing individual administrative loads, and through other services that such an institute could make available to the participating groups. Medical societies would benefit by the assurance that their major function—raising the level of medical practice among their constituents—will be carried out insofar as postgraduate education is concerned. Physicians would benefit by having a central source of information from which they can have a complete picture of postgraduate opportunities available to them. And medicine in general would be strengthened by the increased rapport that could develop from such a cooperative undertaking between the schools and societies. Finally, and most important, the public will benefit by better trained up-to-date physicians who can render them the best of medical care.

Such a program would of course cost money to operate, but the benefits and savings over a long period of time would more than justify the expenditure. However, these costs could be met by contributions of a substantial size from the medical societies, voluntary health agencies and health departments, and by token contributions from the medical schools. In addition contributions from foundations and industry could probably play a strong part in financing. Finally, as the service to the physicians in the area becomes more evident to them

the institute could gradually become relatively self-supporting through subscriptions to its services by individual physicians.

A REGIONAL APPROACH

So far we have been discussing this matter with Baltimore and its environs as the point of reference. However, everyone here is undoubtedly aware of the large amount of "interstate commerce" that is taking place among both the teachers and students of postgraduate education. In actual practice state boundaries or city limits have little bearing upon where physicians attend postgraduate courses. Distance itself is of vital concern, and in the last analysis we find that postgraduate education operates on a regional rather than a statewide or national level. In the light of the complexities of any coordinating plan that might evolve from these beginnings, it might be worthwhile to consider the solution of your problems on a regional rather than a city or statewide basis. By so doing the total need would of course be increased but so would the resources, and this might give the somewhat ambitious sounding program suggested, a broader base upon which to develop.

In the course of the nationwide study of postgraduate education presently being completed by the Council on Medical Education and Hospitals of the A.M.A., it was convenient to make certain statistical breakdowns on a regional basis. The region into which your area falls includes the States of Maryland, Virginia, West Virginia, North Carolina, South Carolina and the District of Columbia. Approximately 13,000 physicians practice in this region, over 60% of whom are general practitioners. Whereas the physicians practicing in the region represent 7.8% of the nation's total, at the present time only 1.6% of the nation's postgraduate opportunities are offered in this area. The Council's survey also shows that the percentage of physicians in this region attending postgraduate courses at all was about the same as for the nation as a whole, but—no doubt because of the relative lack of opportunities—the average amount of time spent in postgraduate attendance by each physician in the region is substantially lower than the national mean. As an indication of the regional nature of this activity it was found that less than $\frac{1}{2}$ of the courses attended by

physicians in this region were within their own state. Fifteen per cent were in an immediately adjacent state and forty per cent in a more distant state.

To meet the postgraduate needs of this 160,000 square mile region there are considerable educational resources. There are twelve medical schools in whose catalogues are listed over 3600 full and part time faculty members. In addition there are two schools of public health, and each of the states has a medical society and a health department. Besides these there are numerous regional, state and local general and special medical societies, a number of voluntary health agencies, and over 618 registered hospitals. The inclusion of the District of Columbia in the region makes available the resources of a number of federal agencies, such as the National Institutes of Health. At present we have definite knowledge of 56 different institutions in this region engaged in some way in postgraduate education, and in 1952-53 this group put on a total of 64 courses, which contained over 2200 instructional hours.

The region that has just been described may seem large from the point of view of individuals in any one of its units. On the other hand, from the national standpoint, this region is relatively small compared with some others. The regions are arbitrarily delineated for which reason they may not be the most ideal working groups. However, any regional plan developed should include a number of states and a number of medical schools in order to distribute the

responsibility more equitably. And in order to have adequate economic support the region should be large enough to include a fairly large number of physicians.

CONCLUSION

Many of the individual courses offered in this region have been excellent postgraduate programs. But the fact that this meeting has been called is in itself evidence of the recognition of a need for some form of coordinated effort in this field. Whether this be on a local or regional level, it will be a step ahead in aiding physicians in continuing their medical education. Undergraduate medical education under the leadership of men like Welch and Flexner rose from a state of chaos to a place of worldwide leadership in the first quarter of this century. In the last twenty-five years we have seen similar progress in graduate training. There remains the third and final phase of medical education—the postgraduate—to be put in order. This is the next big step ahead for medical education in the years before us. Efforts such as those being contemplated by this group will doubtless play a significant role in setting examples for other areas of the country to follow, beyond the inherent value of your program to your own community.

*113 East Oak Street
Chicago, Illinois*

ANNOUNCEMENT OF REGULAR CORPS EXAMINATIONS FOR MEDICAL OFFICERS UNITED STATES PUBLIC HEALTH SERVICE

A competitive examination for appointment of Medical Officers to the Regular Corps of the United States Public Health Service will be held in various places throughout the country on February 15, 16, and 17, 1955.

Application forms may be obtained by writing to the Chief, Division of Personnel, Public Health Service, Department of Health, Education, and Welfare, Washington 25, D. C. Completed application forms must be received in the Division of Personnel no later than January 12, 1955.

Component Medical Societies



BALTIMORE COUNTY MEDICAL ASSOCIATION

WILLIAM A. PILLSBURY, M.D.

Journal Representative

The first fall luncheon meeting of the Baltimore County Medical Association was held on Wednesday, September 22, at the Stafford Hotel. The meeting was featured by a Medical Care Panel which was organized for the purpose of explaining both the County and Baltimore City medical care programs to the members of the Baltimore County Medical Association.

Mr. W. W. MacVicar was the moderator of the panel which was comprised of the following members:

Dr. Lowell J. Reed, President of the Johns Hopkins University

Dr. Huntington Williams, Commissioner of Health of Baltimore City and member of the State Board of Health

Dr. J. Wilfrid Davis, Director of the Division of Medical Care of the Baltimore City Health Department

Dr. Mark V. Ziegler, Director of the Bureau of Medical Services and Hospitals of the Maryland State Department of Health

Dr. Wetherbee Fort, practicing physician in Baltimore City and Past President of the Baltimore City Medical Society

Dr. Melvin B. Davis, practicing physician in Baltimore County and Past President of the Baltimore County Medical Association.

Each panel member gave a short talk on various aspects of the two programs following which questions were directed at the panelists by the audience.

The meeting was well-attended and the members derived a great deal of information from the excellent talks and discussion.

MONTGOMERY COUNTY MEDICAL SOCIETY

DEWITT E. DELAWTER, M.D.

Journal Representative

Dr. James P. McCarrick has been appointed local editor for the Montgomery County sponsored issue

of the Maryland State Medical Journal, which is to be published in about one year. Any members of the Society having any writing in progress or planned may contact Dr. McCarrick if they wish to have it included in the "Montgomery County" issue. It is desired to have at least one article concerning medical and hospital facilities of the County.

The Maryland State Board of Health has named Dr. Gilcin F. Meadors, research specialist at the National Cancer Institute in Bethesda, as deputy health officer for Montgomery County. He succeeded Dr. V. L. Ellicott, who resigned last July 31, and assumed his duties November 1.

Dr. J. W. Bird received a citation from the State Society at the last meeting for outstanding services of more than twenty years in the County Medical Society. The Society is grateful to Dr. Bird for his long services and congratulates him on this attainment.

On November 16, 1954 the County Medical Society sponsored its annual dance at the Woodmont Country Club. Dr. Maynard Cohen had charge of the arrangements and the Ladies Auxiliary managed the tickets and the reservations. Everyone who attended had a very pleasant evening.

The 1954 Diabetes Detection Drive in Montgomery County was directed by Dr. George Sharpe who was well assisted by the Ladies Auxiliary and other groups of the County. This was the first year that the St. Louis Drey-Pak was used for testing specimens in this County. This method represented a tremendous improvement over previous systems and eliminated many difficulties encountered in former years. All of the physicians of the County were asked to test urine specimens brought to their offices during the week of the drive as a public service. Although the results of this year's campaign have not been reported, it was certainly more successful than any previous drive. The County Medical Society contributed \$150.00 toward the expenses of this year's Diabetes Detection Drive.

WASHINGTON COUNTY MEDICAL SOCIETY

SIDNEY NOVENSTEIN, M.D.

Journal Representative

The Semiannual Meeting of the Medical and Chirurgical Faculty of the State of Maryland was

held in Hagerstown, Maryland on Thursday, September 30, 1954.

The morning hours were devoted to business sessions of the Faculty and Woman's Auxiliary, while the afternoon hours saw two fine scientific presentations, the first by Dr. Julian Johnson who spoke on "Diagnostic Problems in the Thorax" and Dr. Edward J. Stieglitz on "Geriatric Diagnostic Difficulties."

During the afternoon while the Scientific Session was in progress, the ladies visiting Hagerstown were conducted on three highly interesting tours and bridge was available.

Dr. Archie Robert Cohen, President of the Host Society, the Washington County Medical Society, introduced the various dignitaries in one dining room at luncheon, while Dr. S. Earl Young, Vice-President of the Host Society introduced other dignitaries in a second dining room. It was necessary to use all the available dining facilities of the Hotel Alexander, because of the very large registration at this meeting.

At the conclusion of the afternoon activities, the Washington County Medical Society was host to the Medical and Chirurgical Faculty and visitors at a reception. This reception was attended by approximately 500 of the good friends and colleagues of the Washington County Medical Society.

The reception receiving line consisted of:

Dr. Archie Robert Cohen, President, Host Society
Dr. Bender B. Kneisley, President, Medical and Chirurgical Faculty

Dr. Cowles Andrews, Chairman of the Council of the Medical and Chirurgical Faculty

Dr. S. Earl Young, Vice-President of the Host Society

Dr. Everett S. Diggs, Secretary of the Medical and Chirurgical Faculty

Dr. Ernest F. Poole, Secretary-Treasurer of the Host Society

Dr. J. Albert Chatard, Treasurer of the Medical and Chirurgical Faculty

Dr. Beverley Compton, Chairman of the Committee on Scientific Work and Arrangements of the Medical and Chirurgical Faculty

SELECTIVE SERVICE SURVEYING MEDICAL MANPOWER POOL

The AMA Washington Letter, No. 97

Selective Service has launched its most extensive survey of medical manpower. Headquarters hopes to have on hand by December 1 the following important data: (1) total number of living registrants under the regular draft who are either physicians or dentists, (2) numbers in each regular Selective Service classification. Armed with this data, Selective Service will be prepared to answer questions expected to come from Congress when it takes up the extension of the regular draft and what to do about the Doctor Draft (both expire next June 30). The information also will help the Defense Department to decide how many of the approximately 1,325 physicians who will be completing their internships next June to defer for residencies. Officials are concerned that many non-veteran physicians have delayed joining the Defense Department's commissioning program on the theory that the Doctor Draft will be allowed to die and they will have no further obligation. Assuming that the regular draft will be extended, they will have a two-year obligation under that law, an obligation which must be served before their 35th birthday. Unless they sign up for a commission in one of the medical corps they might have to serve the two years as enlisted men, like other registrants. Congress has made clear that men brought in under the Doctor Draft are to be offered commissions, but this guarantee does not apply to the regular draft.



Library



"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

PEPTIC ULCER

LOUIS KRAUSE, M.D.*

The story of dyspepsia and peptic ulcer goes back to time immemorial. Although we have no clear distinction recorded by the ancients of the various forms of dyspepsia, since human beings are essentially today what they were 2 or 3 millenia ago, the probabilities are that peptic ulcer existed in antiquity. A good record in engraving of peptic ulcer was given as early as 1799 by Matthew Baillie.

Certainly the medicine men were aware of the presence of various conditions causing dyspepsia. Today we realize how manifold the causes are for it. Frequently this complaint is caused by disease not in the stomach. This has given rise to the expression that the "stomach is the biggest liar in the body." The separation of malignancy and ulcer in the stomach was only made relatively recently and even today, we cannot be certain clinically without microscopic evidence. It is interesting that a review of the pathologic slides of the lesion in the stomach of Napoleon Bonaparte now indicates that he probably had not a cancer of the stomach, but a bleeding ulcer with hemorrhage.

The causes of many of the conditions in the stomach still escape us in spite of all the recent advances. One can pursue the subject of peptic ulcer from the historical point of view to its modern approach in the following list of books available in the Faculty Library.

Peptic ulcer

- Baillie, M. The morbid anatomy of some of the most important parts of the human body. 1st. Am. ed. Albany, Barber & Southwick, 1795.
- Baillie, M. A series of engravings, accompanied with explanations, which are intended to illustrate The

morbid anatomy of some of the most important parts of the human body. London, W. Bulmer, 1799.

Curling, T. B. On acute ulceration of the duodenum in cases of burn. *In* Medico-Chirurgical Transactions, vol. 25. London, Royal medical and chirurgical society, 1842.

Fenwick, S. and Fenwick, W. S. Ulcer of the stomach and duodenum and its consequences. Philadelphia, Blakiston, 1900.

Moynihan, B. G. A. Duodenal ulcer, Philadelphia, Saunders, 1910. 2d. ed. 1912.

Bolton, C. Ulcer of the stomach. London, Arnold, 1913.

Ryle, J. A. Gastric function in health and disease. London, Oxford, 1926.

Crohn, B. B. Affections of the stomach. Philadelphia, Saunders, 1927.

Hurst, A. F. and Stewart, M. J. Gastric and duodenal ulcer. London, Oxford, 1929.

Buskstein, J. Peptic ulcer, clinical roentgenology with case histories. N. Y., Hoeber, 1930.

Heuer, G. J. The treatment of peptic ulcer. Philadelphia, Lippincott, 1944.

Cook, D. Ulcer, the primary cause of gastric and duodenal ulcer. Chicago, Medical center foundation and fund, 1946.

Deller, F. C. The modern management of gastric and duodenal ulcers. Baltimore, Williams & Wilkins, 1948.

Ivy, A. C., Grossman, M. I., and Bachrach, W. H. Peptic ulcer. Philadelphia, Blakiston, 1950.

Schindler, R. Gastroscopy—the endoscopic study of gastric pathology. 2d. ed. Chicago, University of Chicago press, 1950.

Doll, R. and Jones, F. A. Occupational factors in the aetiology of gastric and duodenal ulcers. London, H. M. Stationery office, 1951.

Sandweiss, D. J., ed. Peptic ulcer; clinical aspects, diagnosis, management. Philadelphia, Saunders, 1951.

* Chairman, Library Committee.

Health Departments

BALTIMORE CITY HEALTH DEPARTMENT

The Baltimore City Advisory Committee On Medical Care

The regular Fall meeting of the Baltimore City Advisory Committee on Medical Care was held on the afternoon of October 27 in the office of the Commissioner of Health. This large and important committee has the responsibility for advising the Commissioner of Health on matters pertaining to the Baltimore City Medical Care Program. It held its first meeting on September 22, 1947 during the stage of careful planning and nearly a year before the program was put into operation. Meetings are held regularly in January, April and October; also, special meetings may be held at the call of the Chairman. The members of the committee, 19 in number, are as follows:

Dr. Ernest L. Stebbins, Chairman; *Director, Johns Hopkins School of Hygiene and Public Health.*

Dr. George M. Anderson; *Member, State Board of Health.*

Mr. Charles S. Austin, Jr.; *President, State Board of Pharmacy.*

Dr. Alan M. Chesney.

Mrs. Henry E. Corner.

Dr. Lewis P. Gundry; *President of the Baltimore City Medical Society.*

Mr. William Galvin.

Dr. Russell Nelson; *President of the Baltimore Hospital Conference.*

Dr. Maurice C. Pincoffs.

Dr. Robert H. Riley; *Director, Maryland State Department of Health.*

Dr. Conrad Acton; *President of the Maryland Academy of Medicine and Surgery.*

Miss Ethel Turner.

Dr. Theodore J. Graciano; *President of the East Baltimore Medical Society.*

Miss Esther Lazarus; *Director of Welfare of Baltimore City.*

Dr. Samuel Wolman; *Assistant Professor Emeritus of Medicine, Johns Hopkins School of Medicine.*

Dr. Charles T. Woodland; *President of the Monumental City Medical Society.*

Dr. H. Boyd Wylie; *Dean of the University of Maryland Medical School.*

Dr. George H. Yeager; *Chairman of the Medical Care Committee of the Maryland State Planning Commission.*

Dr. Huntington Williams; *Commissioner of Health of Baltimore City, ex officio.*

At the meeting on October 27 the agenda followed the usual pattern. First, a detailed statistical and narrative report was presented covering the activities of the Baltimore City Medical Care Program since the last meeting of the Advisory Committee. This report was followed by a detailed statement of the expenditures of funds, supported by documentary material.

After free discussion of these reports the committee considered the budget request of the Commissioner of Health for the State financial year starting July 1, 1955. Then there was a review of the future conduct of the program which affects the medical care of about 29,000 persons on public assistance. It is of interest that the membership of the Committee includes four members of the Maryland State Board of Health.

Huntington Williams, M.D.

Commissioner of Health

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, October 29–November 25, 1954

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County.....	28	—	1	2	—	—	1	1	1	—	10	—	—	18	11	1	5	c-1	7
Anne Arundel.....	2	—	—	2	9	—	—	3	—	—	—	—	—	—	4	—	2	—	3
Howard.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	2	1	—	1
Harford.....	—	—	—	—	—	—	6	—	2	—	3	—	—	—	2	—	1	—	3
Carroll.....	1	—	—	3	—	—	—	—	—	—	1	—	—	1	—	—	—	—	1
Frederick.....	7	—	—	14	—	1	8	—	—	—	11	—	—	—	—	—	6	t-1	—
Washington.....	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	2	—	1
Allegany.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Garrett.....	—	—	—	1	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—
Montgomery.....	4	—	1	4	4	—	7	4	1	—	4	—	—	1	7	—	2	—	4
Prince George's.....	2	—	1	2	4	1	11	1	1	—	5	—	—	2	5	—	2	—	3
Calvert.....	—	—	—	2	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—
Charles.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Saint Mary's.....	—	—	—	1	—	—	—	—	—	—	2	—	—	15	—	—	1	—	2
Cecil.....	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—	1
Kent.....	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Queen Anne's.....	—	—	—	—	—	1	—	—	—	—	—	—	—	1	—	—	2	—	—
Caroline.....	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	2	—	—
Talbot.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	11	—	2
Dorchester.....	—	—	—	1	—	—	—	—	1	—	1	—	—	—	1	—	5	—	—
Wicomico.....	8	6	—	—	1	—	4	1	—	—	3	—	—	—	5	—	12	—	1
Worcester.....	3	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Somerset.....	—	—	—	—	—	—	13	—	—	—	2	—	—	—	—	—	1	—	1
Total Counties.....	57	6	3	32	18	3	51	11	7	0	42	0	0	40	39	3	55		31
Baltimore City.....	27	1	0	5	2	1	19	2	2	0	16	0	0	38	81	7	435	c-2	23
State																			
Oct. 29–Nov. 25, 1954..	84	7	3	87	20	4	70	13	9	0	58	0	0	78	120	10	490		54
Same period 1953.....	149	0	11	18	154	7	165	13	12	1	43	2	2	39	136	11	493		31
5-year median.....	118	3	7	—	65	2	55	52	—	0	59	2	3	58	185	29	600		36
Cumulative totals																			
State																			
Year 1954 to date....	3107	22	301	756	11412	34	2828	144	94	21	1386	17	6	839	1950	153	6953		480
Same period 1953.....	2893	11	1450	447	1704	73	2487	288	213	25	2265	31	12	375	2093	142	7272		636
5-year median.....	3195	27	955	—	4288	48	1626	389	—	55	982	28	36	572	2488	385	6947		515

c = congenital syphilis under 1 year of age.
t = tularemia.



Blue Cross - Blue Shield



THE DILEMMA IN CATASTROPHIC INSURANCE¹

E. A. VAN STEENWYK²

"While Blue Cross and Blue Shield and other insurance plans have met the uncertainty of most of the expense in the hospitalized case, the coverage now available has limits, if not in dollars as under indemnity insurance plans, then in days or in service as under Blue Cross and Blue Shield. It is, therefore, just as natural that insurance coverage now would be extended to provide for this additional care. This is the basis for the present interest in catastrophic or major medical expense insurance which is becoming increasingly important to the insurance industry.

"In addition to comments from labor, industry and subscribers, medical and hospital leaders also have continuously pointed to the need for broader and more extensive Blue Cross and Blue Shield coverage. Hospital leaders and doctors have urged that the aged, the unemployed and the presently ill be made eligible for health insurance. How all of this can be done at low cost remains an unanswered question. Yet unless the needs of all Americans are met by voluntary health insurance at reasonable cost, there can be no question that health care increasingly will become a subject for political consideration.

"Today's market unquestionably calls for reconsidering the needs and desires of buyers of insurance by all sellers of insurance. No amount of assurance that the need for such coverage is slight will make much difference in demand. The people want inclusive coverage against all sickness costs and producers of the service want them to have coverage against the major expense of illness. Technical problems of insurance and merchandising are the chief obstacles in the way.

"It could be said that the same need for catastrophic health insurance existed when Blue Cross began. Everybody in the field was so busy doing the larger and more important task of getting a broad base of

enrollment that little attention was paid to the inadequacies of coverage, the infrequent cases remaining in the hospital more than 21 or 30 days, the usual period of hospital care then provided by Blue Cross. Or, it could be said that medical care has changed so much that our insurance contracts have not been adjusted sufficiently to meet the new situation. Both propositions have elements of truth in them but it doesn't really matter why the inadequacy is now apparent. Demand for more extended coverage is here.

"If the price for health insurance gets too high, many now covered will abandon coverage and be unprepared for medical care costs when they must be met. This, of course, would be the greatest tragedy to hospitals and doctors who have so universally cooperated in the establishment of voluntary insurance. This is where voluntary insurance came in. If it now became unpopular because of price it could then also be where voluntary insurance went out.

"Hospitals, and doctors as well, have changed their mode of operation since health insurance became an important source of their revenue. Part of this was caused by changes in medical care methods and techniques. An important reason for the change, however, has been the insurance dollars themselves. Hence, there will probably not be a return to medical care financing as we knew it in the 20's and before that time. If voluntary nongovernment insurance cannot do the job the people want done, our state capitals and Washington itself are full of people who have another answer to the problem. It is clear, therefore, that Blue Cross and Blue Shield must be alert to the possibility that it is possible to price their coverage out of the market. It is also clear that hospitals and doctors have an important stake in not having this occur.

"The insurance concepts used in catastrophic or major medical expense insurance now are being defined by the insurance companies operating in this field, many of whom have done much original re-

¹ Excerpts from article originally published in the July 1954, *Hospitals* magazine.

² Executive Director of the Associated Hospital Service of Philadelphia.

search into the problems of the coverage. Such definition is necessary for orderly development and administration, but it will not be easy because so much depends upon the judgment of a single person—the doctor in charge of the case.

“The definition of catastrophic creates another special problem. What is a catastrophe? How long does it run? If definition of catastrophe includes a single disorder or disability, what happens when an insured with a heart disability simultaneously needs treatment for cancer? Or when a physical disorder results in a mental illness which was incipient at the

time of first treatment for the physical disorder? If the limits of liability to the insurance company are expressed in service or dollars per disability, to what is the insured entitled? There are answers to such questions. Some are to be found in the provisions of the insurance contract or policy.

“The fact that the insurance is new and with little experience to draw upon, suggests that a fluid and ever-changing series of concepts will be used in the offer, sale and administration of such insurance, of the diseases, and of the time the insurance is effective.”

MRS. HOBBY PRESSES REINSURANCE AT LIFE INSURANCE CONVENTION

The AMA Washington Letter, No. 93

Secretary Hobby is continuing to press for enactment of the federal reinsurance program defeated in the last Congress. Her latest activity was at the American Life Convention meeting in Chicago, where she devoted a large part of her talk to this subject. Mrs. Hobby said the administration is backing reinsurance because “. . . time is running against those who seek to keep health insurance on a voluntary basis.” She added: “We still strongly believe in a bill . . . which seeks to compress the experimentation of the next 20 years into less than half the time through the simple mechanism of a broad sharing of risks. We believe such a bill will . . . nurture rather than weaken the voluntary health insurance concept.”

The American Medical Association opposes reinsurance on the grounds that (a) the insurance carriers themselves have all the reinsurance money needed, (b) voluntary health insurance is making “extremely rapid” progress without reinsurance, (c) reinsurance would not make uninsurable risks insurable, and (d) without an objectionable subsidy reinsurance would not reduce the cost of insurance or “overcome the inertia of the unwilling buyer.”

PRESIDENT CONFIRMS PLANS TO RESUBMIT REINSURANCE BILL

The AMA Washington Letter, No. 94

President Eisenhower, in an address October 21 in New York City, served notice he would resubmit his health reinsurance plan to the next Congress and promised that it would be “an important part of a health program in the great gaps in the field of health.” He added: “. . . we are years behind our potential achievement in the availability and adequacy of health services.” His remarks on reinsurance came the same day that Secretary Oveta Culp Hobby in one of her rare press conferences said a Department of HEW task force would soon have a “clearer and better” bill to present to the President. Asked about objections of the AMA to reinsurance, which was defeated in the House this year, Mrs. Hobby stated: “I very much hope that the AMA will see its way clear to support health reinsurance. We have the same objectives, the difference is only one of method.” Along with much of the insurance industry, the U. S. Chamber of Commerce and many other groups, the AMA opposed reinsurance as being unnecessary, as holding out false promises and as introducing the federal government into an area where it does not properly belong. Asked why HEW was holding up comment on Defense Department’s medical scholarship plan, Mrs. Hobby explained it had been brought to her personal attention only within the last month or five weeks.

Ancillary News

NURSING SECTION

M. RUTH MOUBRAY, R.N., *Executive Secretary,*
Maryland State Nurses Association

NURSING IN CIVIL DEFENSE IN MARYLAND¹

ELIZABETH GEDDES²

For the first time in many generations we are faced with a situation in which we know an enemy has the power to attack our country with strong force, with or without warning. Since the enemy's objective would be to cripple or destroy the productive capacity of this country and disrupt civilian morale, it seems likely that a devastating attack would be made against points selected to cause the greatest strategic damage in the shortest time. Civil Defense authorities are agreed that Baltimore and Washington would constitute major target areas.

The Armed Forces, whose major concern must be military offense and defense, could give little assistance; therefore, reduction in the number and severity of casualties and prompt orderly restoration of community life will depend upon a well-informed, well-organized and well-trained civilian population. The knowledge on the part of the enemy that the home front is so organized and trained might well be a strong deterrent to the aggressor.

While it is recognized that Baltimore and Washington, because of density of population, concentration of important industries, location of communication and transportation centers, critical military facilities and civil government are considered as critical target areas and the center about which all civil defense activities must revolve, the attack on either of these areas would be a threat to the entire Eastern Seaboard. The plan for civil defense is one in which every man, woman and child, whether near or far from a target area, should have a part to play; firstly, by preparing for self-help in time of disaster; and secondly, by cooperating with neighborhood and other communities in extended self-protection. Since

no area can be expected to provide completely for its own self-protection and recovery after attack, the operation of Civil Defense depends on inter-community assistance (Mutual Aid) and State-directed support in which existing resources of the State or even other states are mobilized for coordinated action.

While every citizen, then, has a part to play in Civil Defense, the medical and nursing profession, in peace as in war, have a peculiar responsibility for the saving of life and the maintenance of health. Early in the development of planning for Civil Defense, nurses identified their responsibilities as follows:

1. Initiation of a survey to establish and maintain an up-to-date and complete register of all professional and licensed practical nurses resident in each political sub-division.
2. Organization of nursing services on both state and local levels.
3. Development of an educational program for professional nurses, nurse aides and volunteers.
4. Recruitment, assignment and continued training of nursing personnel within the several types of local Civil Defense units as developed.

SURVEY OF NURSING RESOURCES

The registration of professional nurses, begun at different times and proceeding at different pace in different locations, has continued to be a function of the local Civil Defense organizations. It remains a challenge to each local group to maintain this register as complete and as up-to-date as possible.

ORGANIZATION OF NURSING SERVICES

In the State of Maryland, the State Department of Health is charged with the responsibility of or-

¹ Submitted by Maryland State Nurses Association.

² Chairman, Committee on Nursing and National Defense, Maryland State Nurses Association.

ganizing the health services for Civil Defense. Within the Medical Personnel Section is a Nursing Unit, with the Chief of the Division of Public Health Nursing, Maryland State Department of Health, as its head. It is through this Unit, with its Advisory Committee broadly representative of nursing interests in Maryland, that State-wide plans and policies are developed concerning the participation of nurses in the Civil Defense program in Maryland.

Similarly, under the city and county Civil Defense organizations, a nursing director with appropriate advisers, is responsible for the development of the nursing program in her jurisdiction.

DEVELOPMENT OF THE EDUCATIONAL PROGRAM

In the early planning of the Federal Civil Defense Administration, an institute on the *Nursing Aspects of Atomic Warfare* was held under Federal auspices in Rochester in November 1950. Maryland nurses were challenged by the opportunity offered to them and a group of ten nurses, representing local and State official health agencies, hospitals and the Maryland State Nurse Association attended.

In December 1950, these ten nurses, together with the directors of the agencies which they represented, met to discuss standardization of teaching content of a proposed manual on Civil Defense Nursing and to enlist the participation of all concerned in the preparation of the required material. This manual entitled "*Suggested Content for the Training Program in Civil Defense Nursing*," Parts I & II (covering the background in information in relation to atomic, biologic, and chemical warfare) was promptly completed with the assistance of many medical and nursing consultants. Before starting the teaching programs, supplementary courses were given to the ten nurse instructors for their further information relative to hematology and the effects of radiation on body tissue, the use of current antibiotics and of intravenous techniques in disaster situations. Following the completion of this manual, the same group met again to plan for the participation of the ten instructors in a State-wide program to enlarge the group of potential instructors and to organize ten-hour courses, first for the employed personnel of organizations and institutions, and secondly for all graduate nurses who could be interested in such training.

In the 23 counties of Maryland and the City of Baltimore a total of approximately 3,000 professional nurses completed the course of instruction based on Parts I & II by April 1951.

Concurrent with this orientation program, work proceeded on the development of Parts III & IV (covering nursing functions and procedures in disaster nursing) which was completed in February 1952. Following its publication, a two-day institute was held in Baltimore under the auspices of the Nursing Unit.* A total of 152 nurses attended this Institute, representing hospitals and health agencies throughout the State.

The progress has admittedly been somewhat slow, some of which may be due to the fact that in certain local areas the required resources and facilities need to be sought outside the local community. To make the program really effective, broad areas of practice must be developed, particularly in the field of intravenous injections and obstetrics, inasmuch as nurses in time of disaster will be expected to assume certain responsibilities not previously required of them. This is a long-range and continuing program about which the nurses are much concerned at the present time and which requires the whole-hearted support not only of the nursing but the medical profession as well.

In addition to these educational programs focused immediately on the preparation of graduate nurses for participation within Civil Defense installations, many hospitals have embarked on a long-range program within the school of nursing by correlating Civil Defense nursing in the basic nursing curriculum and by presenting refresher courses to graduate staff. It is hoped that eventually all schools of nursing will have included such courses in their educational programs.

Since it is recognized that there are not sufficient numbers of graduate nurses to meet disaster needs, the Nursing Unit in June 1952 began to focus attention on the development of an educational program for a category of volunteer workers known as "Nurse Assistants." In cooperation with local and National Red Cross, the local and State Civil Defense representatives analyzed the functions of this new worker and outlined the essential training needed to qualify these workers to assist the professional nurse. As an outcome of this joint action, the Red Cross agreed

* To prepare instructors who would then set up educational programs based on the manual within their own institutions.

to extend the present Home Nursing course from 12 to 15 hours, thereby correlating Civil Defense nursing in the course. They also agreed to orient all Red Cross Home Nursing instructors to provide this training. The Civil Defense organizations agreed to recruit students for the classes and to assign them to Civil Defense installations upon graduation from the course.

This initial training was considered to be minimal, and in order to further develop and maintain these beginning skills, the local Civil Defense units are responsible for a continuing in-service training program after assignment. A training manual for this purpose has been made available to the local units.

PARTICIPATION OF PROFESSIONAL NURSING ORGANIZATIONS IN CIVIL DEFENSE

Throughout the development of these various aspects of nursing participation in Civil Defense, the two professional nursing organizations—the Maryland State Nurses Association and the Maryland League for Nursing—have worked together with the Nursing Unit in the development of the entire program. The Chief, Nursing Unit is a member of the Maryland State Nurses Association Committee on Nursing in National Defense and the Chairman of that Committee is a member of the Advisory Committee to the Nursing Unit. One example of a direct con-

tribution of the professional organizations was the work of a joint committee of the organizations in developing a staffing pattern for emergency hospitals which was issued as a Medical Bulletin by the State Medical Services, Civil Defense.

The Maryland State Nurses Association wishes to support the Civil Defense program in every possible way and to work toward the improvement of the preparation of nurses for Civil Defense nursing. Specifically, at the present time, it hopes to carry out the following suggestions made at the meeting of of the Advisory Committee to the Nursing Unit, Civil Defense on March 19, 1954:

1. Keep the Association informed about the developing Civil Defense program through the medium of representation of the Chairman of its Committee on Nursing in National Defense.
2. Keep Civil Defense before nurses through the medium of the Annual Convention and other meetings and publications.
3. Support the dissemination of information on self-help and community participation to the professional nurse population.
4. Support graduate nurse orientation to Civil Defense in the hospital situation.
5. Support inclusion of Civil Defense content into the three-year basic educational program.
6. Support orientation of volunteers in hospitals.

EXCERPTS FROM THE NATIONAL FAMILY SURVEY OF MEDICAL COSTS AND VOLUNTARY HEALTH INSURANCE

Odin W. Anderson, Ph.D.*

Rural areas have less enrollment in voluntary health insurance than urban areas. As measured by families, 70 per cent of urban families have some type of insurance and 45 per cent of rural-farm families. For hospital insurance alone, 63 per cent of the individuals in urban areas carry hospital insurance, and 38 per cent in rural-farm areas. The differences in urban and rural areas are a reflection of the opportunity of voluntary health insurance to enroll employed groups in urban areas and the difficulties of creating groups for insurance purposes in rural areas. Farmers do have access to health insurance policies on an individual basis, but health insurance sold on an individual basis costs more and has more limitations in benefits than group contracts. The chief problem is one of creating groups for health insurance purposes.

* Courtesy of the Health Information Foundation, 420 Lexington Avenue, New York 17, New York. Published January 1954.



Woman's Auxiliary Medical and Chirurgical Faculty



MRS. JOHN G. BALL, *Auxiliary Editor*

SEMIANNUAL MEETING NOTES

Hagerstown, September 30, 1954

The meeting was very well attended and most interesting. All of the organized counties were represented and many members-at-large were present.

Two resolutions were adopted by the Auxiliary:

RESOLUTION NO. 1, HIGHWAY SAFETY

Whereas, 38,000 citizens of this United States were killed in traffic accidents in 1953, more than were killed in the Korean War; and

Whereas, The President of the United States has called for the mobilization of public opinion to aid the legal authorities in the traffic safety battle; and

Whereas, The Woman's Auxiliary to the American Medical Association is concerned with the health and the safety of the citizens of the nation, therefore, be it

Resolved, That the Woman's Auxiliary to the American Medical Association go on record as being in complete accord with President Eisenhower's program on Highway Safety; and be it further

Resolved, That the Woman's Auxiliary to the American Medical Association cooperate with the program as deemed advisable by the Board of Directors and the Advisory Committee.

RESOLUTION NO. 2. ENDORSEMENT OF THE PROGRAM FOR "A FAMILY DOCTOR IN EVERY DOCTOR'S FAMILY" SPONSORED BY THE AMERICAN ACADEMY OF GENERAL PRACTICE

Whereas, The health needs of the American people can adequately be met only if there is an ample number of able and efficient practitioners of medicine, and

Whereas, The health of America's doctors is thus a matter of grave concern not only to the individual doctors, their families and the entire medical profession, but to the public as well, and

Whereas, It is a well recognized and deplorable fact

that the physician is often the last one to heed advice he urges upon his patients and thus often goes without periodic examinations or without the advantage of a personal physician who maintains an accurate health record of the individual physician and the members of his family, and

Whereas, Failure to heed his own advice, and failure to employ the services of a family physician for himself and his family may be directly related to the fact that the average life expectancy of physicians in America is appreciably lower than the average expectancy of males generally, and

Whereas, The members of a physician's family are deprived of adequate and proper medical care if they resort to first one and then another of the physician's medical colleagues with no single individual filling the role of a personal physician for the family and maintaining a continuing health record for each member of the family, and

Whereas, The American Academy of General Practice, at the instigation of its late vice-president, Dr. Merrill Shaw of Seattle, has launched a program to persuade every physician in America to select a regular family physician for himself and his family, and

Whereas, This program, which has attracted widespread attention in newspapers and popular magazines, is setting an important precedent for the lay public, which, if followed, will improve the nation's health and simultaneously the goodwill enjoyed by the medical profession, now, therefore, be it

Resolved, That the Woman's Auxiliary to the American Medical Association commends the American Academy of General Practice for its meritorious efforts in the furthering of this worthy project, and be it further

Resolved, That the Woman's Auxiliary to the American Medical Association hereby endorses the Academy's project and urges every member of the American Medical Association to support the program and cooperate in it by taking upon himself the

responsibility of designating a physician to serve as family physician for his family, thus setting a prime example of good health practice for his patients and the people of his community.

Short reports were given by the presidents of the County Auxiliaries.

1. BALTIMORE CITY, MRS. E. RODERICK SHIPLEY

A card party was held October 27th for the benefit of the Student Aid Fund. The Auxiliary is now attempting to organize Future Nurses Clubs in the high schools. A directory of members is being made. The Med-Chi Ball is being planned for the Spring Annual Meeting. As part of the proceeds from last year's Ball, a check of \$100 was presented to the State Auxiliary to help defray secretarial and office expense.

2. BALTIMORE COUNTY, MRS. THOMAS WHEELER

Five girls are now in nurses training on scholarship provided by the Auxiliary. A Doctor's Day dance is being planned for spring.

3. MONTGOMERY COUNTY, MRS. NORMAN OLIVER

Two nurses are on scholarship from Montgomery County. The aim of the Auxiliary this year is to increase membership. Plans are completed to help with T. B. seals and Diabetic Drive, celebrate Doctor's Day and obtain more subscriptions to "Today's Health." Montgomery County Medical Society held a Dinner-Dance in November which the Auxiliary helped plan.

4. WASHINGTON COUNTY, MRS. B. B. KNEISLEY

Two nurse scholarships are given by Washington County. The Auxiliary plans to work on the Medical Library for the Medical Society and Hospital. Good public relations continue to be uppermost on the program.

A wonderful report on Nurse Recruitment was given by our State Chairman, Mrs. James Kerr, and her Co-Chairman, Mrs. D. D. Caples. A later issue of the JOURNAL will carry this in detail.

Mrs. Thomas Christensen awarded the Past Presidents of the Auxiliary with pins (see seal, Auxiliary

page) inscribed with name and term of service. Mrs. George Yeager, 1951-52; Mrs. Charles Williams, 1952-53; Mrs. John Ball, 1953-54.

The President, Mrs. A. E. Goldstein, gave her worthwhile message. (See November JOURNAL)

The Secretary to Legislation, American Medical Association, Mr. John Martin, gave us a very informative talk which will be printed in the January JOURNAL.

EXPRESSION OF APPRECIATION FOR GIFT TO AMEF

October 12, 1954

Mrs. Whitmer B. Firor

Treasurer

Woman's Auxiliary to Baltimore City Medical Society
4400 Norwood Road

Baltimore 18, Maryland

Dear Mrs. Firor:

In my capacity as chairman of the State Committee to Co-operate with American Medical Education Foundation, I would like to extend to your president, and your splendid co-workers the deepest appreciation of the Committee and the Foundation for your loyal and generous support as manifested by the gift of \$200.00.

The work of the Foundation has made it possible to keep key personnel and make vital adjustments in the heavily overtaxed personnel and facilities of our medical schools. All contributions have maximum effect, for there are no deductions for administrative overhead, as such expenses are borne by the American Medical Association. In addition, these monies are distributed impartially, with all medical schools benefiting. There are no strings attached to the gifts, the use of which is at the discretion of the individual medical school.

Your continued loyalty in efforts, time and money is recognized by the Baltimore City Medical Society to whom you have brought such credit.

Sincerely,

Newland E. Day, M.D.

Chairman of the State Committee
to Co-operate with the A.M.E.F.

Coming Meetings

THE POSTGRADUATE INSTITUTE OF DOCTORS HOSPITAL

Tuesday, January 4, 1955, 9:15 p.m.

2724 N. Charles Street, Baltimore

New Drugs in Mental Disturbances. Enoch Callaway III, M.D., Albert A. Kurland, M.D., and Louis Cholden, M.D.

SECTION ON DISEASES OF THE CHEST*

JOHN E. MILLER, M.D., *Chairman*

EDMUND G. BEACHAM, M.D., *Secretary*

Wednesday, January 5, 1955, 8:00 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Surgical Management of Bronchiectasis with Physiologic Implications. Captain Clifford F. Storey, M.C., U.S.N., Chief of Surgery, Norfolk Naval Hospital and Clinical Professor of Surgery, New York State University.

OTOLARYNGOLOGICAL SECTION*

ALBERT STEINER, M.D., *Chairman*

WALTER E. LOCH, M.D., *Secretary*

Tuesday, January 11, 1955, 6:00 p.m.

Johns Hopkins Club

Function Preserving Operations in Laryngeal Cancer Surgery. DeGraaf Woodman, M.D.

PEDIATRIC SECTION*

JOSEPH M. CORDI, M.D., *Chairman*

SAMUEL S. GLICK, M.D., *Secretary*

Tuesday, January 11, 1955

Dinner 6:15 p.m.: Johns Hopkins Faculty Club, Homewood

Scientific Session 8:30 p.m.: Faculty Building

1211 Cathedral Street, Baltimore

Some Physiological Aspects of Strabismus. (Illustrated.) R. D. Harley, M.D., F.A.C.S., Assistant Professor of Ophthalmology, Temple University Medical School. Discussion to follow speaker.

*Section of the Baltimore City Medical Society.

SYMPOSIUM ON
"TRAUMA OR HEART DISEASE?
PRETRIAL CONFERENCE FOR MEDICAL TESTIMONY"

Wednesday, January 12, 1955, 8:00 p.m.

Osler Hall, 1211 Cathedral Street, Baltimore

PANEL DISCUSSION

HON. EMORY H. NILES, Chief Judge of Supreme Bench of Baltimore City—*Presiding Judge.*

Medical Witnesses:

DR. RUSSELL S. FISHER, Chief Medical Examiner of the State of Maryland—Pathological Findings.

DR. E. COWLES ANDRUS, Associate Professor of Medicine at Johns Hopkins University—Clinical Aspects and Expert Opinion.

Attorney for Plaintiff:

MAURICE J. PRESSMAN of the Baltimore Bar.

Attorney for Defendant:

J. GILBERT PRENDERGAST of the Baltimore Bar.

Sponsored and arranged by the Medicolegal Committees of the Bar Association of Baltimore City, the Maryland State Bar Association, and the Medical and Chirurgical Faculty. Members of these Associations and the general public are cordially invited and urged to attend this meeting.

RADIOLOGICAL SECTION*

JOHN DECARLO, JR., M.D., *Chairman*

PAUL W. ROMAN, M.D., *Secretary*

Tuesday, January 18, 1955

Sinai Hospital

Dinner 6:30 p.m.

Scientific Session 8:00 p.m.

Carcinoma of the Cervix. Sidney Silverstone, M.D., Associate Radiologist, Mt. Sinai Hospital, New York City.

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty

RICHARD W. TELINDE, M.D., *Chairman*

BEVERLEY C. COMPTON, M.D., *Secretary*

1211 Cathedral Street, Baltimore

Thursday, January 20, 1955

5:00 to 6:00 p.m.

*Section of the Baltimore City Medical Society.

JOINT MEETING OF THE DERMATOLOGY SECTION* AND THE
GYNECOLOGICAL AND OBSTETRICAL SOCIETY
OF MARYLAND

RAYMOND C. V. ROBINSON, M.D., *Chairman* EVERETT S. DIGGS, M.D., *Pres dent*
WILLIAM R. BUNDICK, M.D., *Secretary* HARRY BECK, M.D., *Secretary*

Monday, January 24, 1955, 8:30 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

LEUKOPLAKIA AND LEUKOPLAKIA-LIKE LESIONS OF THE VULVA

Clinical Aspects. WILLIAM K. DIEHL, M.D., AND HARRY M. ROBINSON, SR., M.D.
Histologic Aspects. LLOYD KETRON, M.D., AND J. DONALD WOODRUFF, M.D.

MATERNAL MORTALITY COMMITTEE

HUNTINGTON WILLIAMS, M.D., *Chairman* BEVERLEY C. COMPTON, M.D., *Secretary*

Thursday, January 27, 1955, 4:00 to 5:00 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and Baltimore
City Health Department.

* Section of the Baltimore City Medical Society.

POSTGRADUATE COURSES

PEDIATRICS

A SERIES OF PANEL DISCUSSIONS

OSLER HALL, 1211 CATHEDRAL STREET

Thursday, January 6, 1955, 8:30 p.m.

Digestion and Absorption of Foods..... Janet B. Hardy, M.D.
Nutritional Requirements..... Malchijah Spragins, M.D.
Feeding of the Premature Infant..... Harry H. Gordon, M.D.

Friday, January 14, 1955, 8:30 p.m.

Infant Feeding During the First Year..... Gibson J. Wells, M.D.
J. Edmund Bradley, M.D.

Friday, January 21, 1955, 8:30 p.m.

Infant Feeding During the First Year..... Henry M. Seidel, M.D.
Garrett E. Deane, M.D.

Friday, January 28, 1955, 8:30 p.m.

Feeding During the Second Year..... A. H. Finkelstein, M.D.
Marvin Jaffe, M.D.

* * * * *

These courses are given under the auspices of the Baltimore City Medical Society, its
Sections, and the Maryland Academy of General Practice. A cordial invitation is extended
to all members of the Medical and Chirurgical Faculty to attend these courses.

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MEDICAL-HEALTH BUDGETS OF FEDERAL DEPARTMENTS, AGENCIES AND COMMISSIONS FOR THIS FISCAL YEAR

Special Report AMA, No. 23

<i>Agency</i>	<i>Fiscal 1955</i>	<i>Fiscal 1954</i>
Department of Defense.....	\$845,487,500	\$533,311,000
Veterans Administration.....	748,738,563	747,415,264
Department of Health, Education and Welfare.....	395,754,000	340,553,000
Federal Civil Defense Administration.....	28,755,000	26,650,000
Department of Interior.....	28,023,498	27,258,600
Atomic Energy Commission.....	27,000,000	26,565,000
Foreign Operations Administration.....	25,574,300	24,500,000
Department of State.....	12,607,667	14,127,733
Department of Labor.....	6,811,000	8,960,000
Federal Employees Health Program.....	6,000,000	6,000,000
Panama Canal Zone.....	5,600,000	5,448,600
National Science Foundation.....	4,795,000	8,000,000
Department of Treasury.....	2,770,000	2,790,000
Department of Justice.....	1,300,000	1,326,000
Federal Trade Commission.....	1,000,000	1,000,000
Commission on Intergovernmental Relations.....	414,000	500,000
Civil Service Commission.....	358,000	not reported
Department of Commerce.....	278,133	621,000
National Advisory Committee to Selective Service.....	190,000	265,000
Commission on Organization of Executive Branch of Government.....	130,000	500,000
Health Resources Advisory Comm (approx.).....	95,000	91,000
Totals.....	\$2,141,681,661	\$1,775,882,197

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ANNUAL MEETING—1955

MEDICAL AND CHIRURGICAL FACULTY

THURSDAY, FRIDAY, AND SATURDAY, APRIL 21, 22, and 23, 1955

The meeting promises to be informative as well as socially enjoyable. Plan to come! The Sheraton-Belvedere Hotel has set aside a "bloc" of rooms for members desiring hotel accommodations. Make your reservation directly to the hotel.

You are urged to make a notation of the meeting on your calendar of these dates. The Annual Meeting next year will be during the latter part of the week.

Watch for an Annual Meeting "spot" in your November Journal, and each subsequent month until April.

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